

3515 Coolidge Rd ~ Unit A
 East Lansing, MI 48823
 Phone: 517-755-6888
 Fax: 517-657-7759



Name: _____

Date: _____

PATIENT

REGISTRATION FORM

PATIENT NAME LAST FIRST MIDDLE INITIAL				PATIENT DATE OF BIRTH	
HOME ADDRESS		APT. NO	CITY	STATE	ZIP CODE
OCCUPATION • EMPLOYED • RETIRED • STUDENT		SOCIAL SECURITY #	MARITAL STATUS • S • M • D • W	SEX • M • F	HOME PHONE [] Preferred
EMPLOYER		E - MAIL ADDRESS			WORK PHONE [] Preferred
					CELL [] Preferred
RACE (check one) • White • American Indian • Asian • Black or African American • Native Hawaiian or other Pacific Islander • Other Race • Decline to specify			ETHNICITY (check one) • Hispanic / Latino • Not Hispanic or Latino • Unknown • Declined to specify		
			PREFERRED LANGUAGE: _____		
PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN PHONE	REFERRING PHYSICIAN	REFERRING PHYSICIAN PHONE		

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT		DATE OF BIRTH
PRIMARY INSURANCE			SOCIAL SECURITY NUMBER OF SUBSCRIBER:	
INSURANCE ID	GROUP / CODE	EFFECTIVE DATE	POLICY HOLDER'S BIRTH DATE	
ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)				
CITY	STATE	ZIP		

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT		DATE OF BIRTH
SECONDARY INSURANCE			SOCIAL SECURITY NUMBER OF SUBSCRIBER:	
INSURANCE ID	GROUP / CODE	EFFECTIVE DATE	POLICY HOLDER'S BIRTH DATE	
ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)				
CITY	STATE	ZIP		

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Location/Address: _____

Pharmacy Phone Number: _____

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Name: _____

Date: _____

Briefly describe your sleep problem(s) and why you have been referred to our clinic. _____

How does the sleep issue(s) affect your life and daily activities? _____

How did you become aware of the sleep issue(s)? _____

Have you ever been previously evaluated or treated for this sleep problem or any other issues with your sleep? Yes _____ No _____

If **YES**, please describe: _____

What is your usual BEDTIME? _____ AM / PM (weekday) _____ AM / PM (weekend)

What is your usual WAKETIME? _____ AM / PM (weekday) _____ AM / PM (weekend)

How long does it take for you to fall asleep? _____ Hours _____ Minutes

How many hours do you actually sleep at night? _____ Hours _____ Minutes

How many times do you awaken at night? _____ How long are you awake with each awakening? _____ Minutes

Do you nap during the day? Yes ___ No ___ If YES; How often? _____ How long are the naps? _____ hrs _____ mins

Do you have difficulty breathing at night? Yes ___ No ___

If **YES**, please describe: _____

Are you currently on CPAP/BiPap? Yes ___ No ___ If yes: pressure setting _____ cmH2O

Current DME (Durable Medical Equipment Company) Name: _____

List **ALL current or past medication(s)** either **prescription or nonprescription** which have been used to initiate/ maintain sleep.

Name	Strength (MG)	Frequency	Were/are they effective?

	Yes	No	Sometimes
Do you have a regular bed partner?			
Does your bed partner complain you snore?			
Have you ever been told you have a pause in breathing while sleeping?			
Do you find yourself falling asleep when you do not mean to?			
When awakening in the morning do you awaken with a headache?			
When awakening in the morning do you awaken with a dry mouth?			
Do you usually feel tired during the day?			
Do you feel rested or refreshed after you sleep?			
Do you wake up too early and are unable to fall back asleep?			
Do you ever experience restlessness of the legs? (creepy crawling sensation or twitching)			
When falling asleep or trying to fall asleep do experience "restlessness of legs" when lying down before bed?			
If YES, does this feeling get better with movement?			
When falling asleep or trying to fall asleep do you have thoughts racing through your mind?			
If YES does this affect your sleep?			

	Yes	No	Sometimes
Do you suffer from any kind of pain or discomfort when falling asleep or trying to fall asleep? If YES, Where?			
Do you ever feel down, depressed or hopeless? If YES? How often?			
When going to sleep or upon waking do you ever feel paralyzed?			
Do you ever hear things that are not real when trying to fall asleep?			
Have you ever had sudden muscle weakness such as jaw or head dropping, knee bucking, falling on the floor, difficulty talking for 1-2 minutes.			

Check **ALL** which may frequently disturb your sleep:

- | | | |
|--|-------------------------------------|---|
| <input type="radio"/> Heat/Cold | <input type="radio"/> Muscle Cramps | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Chest Pain | <input type="radio"/> Snoring | <input type="radio"/> Nasal Congestion |
| <input type="radio"/> Sweating | <input type="radio"/> Leg Kicking | <input type="radio"/> Pain |
| <input type="radio"/> Heartburn/GERD | <input type="radio"/> Coughing | <input type="radio"/> Gasping for Air |
| <input type="radio"/> Choking | <input type="radio"/> Hunger/Thirst | |
| <input type="radio"/> Urination/How Often?__ | <input type="radio"/> Wheezing | |

FAMILY HISTORY

Does anyone in your family have a sleep problem? If yes, please describe _____

Heart Attack(who?) _____ Stroke(who?) _____ Diabetes(who?) _____

PAST MEDICAL HISTORY

Please indicate any conditions you have or have had in the past:

- | | | |
|--|---------------------------------------|---|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> GERD/Heartburn | <input type="radio"/> Head Trauma |
| <input type="radio"/> Diabetes(I, II) | <input type="radio"/> Anxiety | <input type="radio"/> Seizure/ Epilepsy |
| <input type="radio"/> Stroke | <input type="radio"/> Depression | <input type="radio"/> Nerve/Muscle Disease |
| <input type="radio"/> Heart Attack | <input type="radio"/> Congested Nose | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Heart Failure | <input type="radio"/> COPD/ Emphysema | <input type="radio"/> Thyroid Complications |
| <input type="radio"/> Atrial Fibrillation | <input type="radio"/> ADD/ ADHD | <input type="radio"/> Muscle Cramps/Pain |
| <input type="radio"/> Hypercholesterolemia | <input type="radio"/> Fibromyalgia | <input type="radio"/> CAD |

Others not listed above: _____

Have you ever had any previous Ear, Nose and Throat Surgeries? Yes ___ No ___ If **YES**, Please indicate date.

- Tonsils _____
- Adenoids _____
- Nasal Septum/ Polyps removed _____

SOCIAL HISTORY

- Marital Status: Single Married Divorced Widowed
- Occupation: _____
- Are you a shift worker? _____
- What are your usual work hours? _____
- Are you a tobacco user? Yes ___ No ___ What Type? _____ Previous Smoker? _____
- How often daily? _____ How Long? _____
- Do you use street drugs? Yes ___ No ___ Type _____ Frequency _____
- Any caffeinated beverages? (soda, coffee, tea) _____ cups typical day _____ cups before bed
- Alcoholic beverages? (beer, wine, etc.) _____ cups typical day _____ cups before bed

MEDICATIONS

Please list the name, dosage and frequency of current medications.

NAME	DOSAGE	FREQUENCY

Do you have any know **DRUG ALLERGIES**? Yes ___ No ___ If **YES**, Please indicate the drug, reaction.

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Name: _____

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Office Policy Information Sheet

Name of Patient: _____ Date: _____

PLEASE NOTE: All charges and/or fees are due at the time of service. Please present your insurance card(s) and ID to the office staff with this completed form. We will copy them for your records and return them to you immediately.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Comprehensive Sleep Center for any services furnished to me by that physician. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

FINANCIAL & INSURANCE POLICY: We will be happy to bill your insurance carrier for you. If your insurance requires a referral to a specialist, it is **required** that you have your referral with you **at the time of service**. It is your responsibility to ensure that your referral is current. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and payment is due upon receipt of that statement.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

Minor Patients: For all services rendered to minor patients, the adult listed as responsible party is responsible for payment.

Cancellation: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a \$35 charge for Clinic appointments and \$100 for any Sleep Study appointment.

RETURNED CHECKS: It is our office policy to charge a fee of \$35.00 for any returned checks.

COMPLETION OF PRINTED MEDICAL RECORD FORMS: We will be happy to complete attending physician's statement, insurance and disability forms for our patients. The patient is responsible for payment of \$15.00 for any record request exceeding 25 pages. Please allow 14 business days for completion of forms.

DECLARATION: I have read and I understand the financial policy of the practice, and I agree to be bound by these terms.

Printed Name of Patient / Responsible Party

DATE

Signature of Patient / Responsible Party

DATE