Sleep and Health Medicine
11611 Airport Rd Ste 205, Everett, WA 98204
Phone: 425-502-8075 Fax: 206-337-9653

PATIENT REGISTRATION

Patient's Name (Last, First, MI): _____ Date_____
Date of Birth: _____ Age: _____ Sex: M ☐ F ☐
Address: _____ _____ Apt. # _____
City: _____ State: _____ Zip: _____
Home Number: _____ Mobile Number: _____Email: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____Relationship: _____Phone: _____

INSURED INFORMATION

We will request to scan your ID and insurance card

Primary Insurance: _____
Subscriber Name: _____
Subscribe Birth Date: _____
Member ID #:_____
Relationship to Subscriber: _____

Secondary Insurance: _____
Subscriber Name: _____
Subscriber Birth Date: _____
Member ID #: _____
Relationship to Subscriber: _____

REFERRAL INFORMATION

Primary Physician: _____
Phone #: _____

Referring Physician: _____
Phone #: _____

I hereby authorize my insurance benefits to be paid directly to the provider. I also authorize the clinic to release any information required for the claim(s). **I acknowledge that I am responsible for all balance and charges not covered by my insurance, and a fee of $100 will be charged to the patient if appointment is cancelled with less than 24-hour notice or there is no show, and co-pay is due at the time of service upon check-in.**

I have read and understand the above: Print Name _____

Signature:_____

Date:_____

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PATIENT QUESTIONNAIRE

Please make sure you bring this completed questionnaire with you to your appointment.

Please indicate the main concerns for which you seek help from our sleep clinic:

☐ Snoring ☐ Sleepiness ☐ Fatigue ☐ Breathing Pause ☐ Insomnia ☐ Restless legs ☐ Other

Have you been evaluated in a sleep clinic in the past? Y ☐ N ☐

If "Yes" please complete this section

Where and when _____ Were you diagnosed with obstructive sleep apnea? Y ☐ N ☐
List any other diagnoses _____ Have you been treated with a CPAP machine? Y ☐ N ☐
Are you currently using a CPAP? Y ☐ N ☐ If not, why _____
Have you had a surgery for apnea? Y ☐ N ☐ Have you ever tried a dental device? Y ☐ N ☐

Please complete the following section for all new patients

How loud is your snoring? ☐ No snoring ☐ Mild ☐ Moderate ☐ Loud ☐ Very Loud
How long have you been told you snore? _____
Has your snoring worsened over time? Y ☐ N ☐
Have you ever awakened choking or gasping for air during sleep? Y ☐ N ☐
Has anyone ever told you that your breathing pauses during sleep? Y ☐ N ☐
Have your gained or lost weight in the last year? Y ☐ N ☐ If yes how much? _____
What time do you usually to go to sleep on Weekdays _____ Weekends _____
What time do you usually awaken on Weekdays _____ Weekends _____
How much sleep would you estimate that you get each night? Weekdays _____ Weekends _____
How long does it typically take you to fall asleep? _____
How many times do you wake up at night on average? _____
What usually cause your awakenings? _____
Do you typically have trouble falling back asleep? _____
If you need to use the bathroom, how many times do you usually need to go at night? _____
Have you been feeling tired or sleepy? Y ☐ N ☐ Do you usually doze off while driving? Y ☐ N ☐
Do you take naps? Y ☐ N ☐ If yes, how long? _____ How many days per week do you usually nap? _____
Have you ever taken medications to improve your sleep? Y ☐ N ☐ If yes, which medications and were they effective?
_____

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How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

Note: This refers to your usual way of life in recent times. If you have not done some of these things recently, try to determine the ways in which might be in these situations.

	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theater, meeting or bus)	0	1	2	3
Riding as a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

Total score_____

How often does each item apply to you? (Check the number that applies to you)

	Never or Very Rare	Times Weekly	Times Monthly		Never or Very Rare	Times Weekly	Times Monthly
Restless Sleep				Feeling down or sad			
Wake up with a dry mouth				Difficulty concentrating/focusing			
Wake up with sore throat				Difficulty with memory			
Wake up with morning headache				Irritable most of the day			
Wake up feeling non-restful				Erectile dysfunction (men only)			
Difficulty waking up				Sleep walking			
Nasal or Sinus Congestion				Sleep talking			
Heartburn				Leg cramps			
Clenching/Grind teeth				Restlessness or discomfort of the legs at bedtime			
Nightmares				Urges to move legs			
Acting out dreams while sleeping				Momentary paralysis when falling asleep			
Feeling tired or sleepy				Sudden muscle weakens brought on by strong emotion			

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Past Medical History

Please check all that apply

Heart Attack	☐	Ulcers	☐	Smoking	☐	Arthritis	☐
Heart Disease	☐	Acid Reflux	☐	Asthma	☐	backpain	☐
Heart Failure	☐	Liver Disease	☐	Emphysema/COPD	☐	Neck Pain	☐
Irregular Heartbeats	☐	Colitis	☐	Recurrent sinus infection	☐	Knee/hip pain	☐
High blood pressure	☐	Irritable bowel syndrome	☐	Allergies	☐	Shoulder pain	☐
High Cholesterol	☐	Diabetes	☐	Nasal Congestion	☐	Fibromyalgia	☐
Head Injury	☐	Hypothyroidism	☐	Depression	☐	Stroke	☐
Prostate enlargement	☐	Hyperthyroidism	☐	Anxiety Disorder	☐	Seizure disorder	☐
Kidney disease	☐	Tonsil/Adenoid remove	☐	Bipolar	☐	Parkinson's disease	☐
Anemia (any history)	☐	Nasal Surgery	☐	Cancer	☐	Migraine headaches	☐

Other: _____

_____

Medication

Are you allergic to any medications? Y☐ N☐ If yes, please list the names of the medications:

_____

List all medications, including over the counter medications and supplements

Medication	Dosage	Times per day

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Your Family History

Does anyone in your immediate family (parents, sibling or children) have the following medical conditions?

Father ☐ Mother ☐ Sibling(s) ☐ Child ☐

☐ Sleep Apnea ☐ Heart Disease ☐ Stroke ☐ Snoring ☐ Narcolepsy ☐ High Blood Pressure
☐ Insomnia ☐ Restless legs syndrome

Your Social History

Marriage status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner

Work Status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

Occupation: _____ What is your highest level of education completed?_____

How many caffeine-containing beverages do you consume on a typical day?

Coffee_____ Tea_____ Caffeinated soft drink_____ Last drink of the day _____

How often do you drink alcoholic beverages?_____ Do you use illicit street drugs? Y ☐ N ☐ If yes, please list

_____

Tobacco use: ☐ Never ☐ Current smoker ☐ Former smoker and quit date _____

Current weight_____Weighted 5 years ago_____ Height_____ If known neck size_____

Feel free to write down any other issues you might have in regards to your sleep.

_____

_____

_____

_____

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Cancellation/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if you do not call to cancel an appointment at least 24 hours in advance, you will be charged a 100-dollar ($100) fee; this fee will not be covered by your insurance company.

Account balances

We will require that everyone with an overdue balance pay off the balance prior to scheduling a new appointment or receiving further services.

Late fee

We will charge a $25 monthly late fee for the overdue balance until your balance has been paid off. We will turn your invoice over to Olympia Collection Inc if your invoice reaches 90 days past due.

We thank you for your choosing our clinic and understanding our policies.

I acknowledge that I have read and understand the above policies, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by our clinic.

Name _____

_____
Relationship to Patient (if the patient is a minor)

_____ _____
Signature Date