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NEW PATIENT REGISTRATION FORM

Date ______________

PATIENT INFORMATION

Whom may we thank for referring you? ______________________________

Name (Last, First, MI) ______________________________ Age __________

Gender ____________ Date of Birth ________/________/________ Marital Status ____________

Address ______________________________ Apt# __________

City ______________________________ State ____________ Zip ____________

SSN: ________/________/________ Email ______________________________

Home Phone ____________________ Work Phone ____________________ Ext ________

Mobile Phone ____________________ Other Phone ____________________

Employer ______________________________

Emergency Contact ______________________________ Phone ____________________

INSURANCE INFORMATION:

Please note that if your carrier requires Pre Authorization or Pre Approval you are required to obtain prior to your appointment. You may need to check with your carrier if you have a waiting period.

Primary Ins ______________________________ Ins Phone ____________________

Primary Ins Address ______________________________

Subscriber ____________________ DOB ____________ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins ID# ______________________________ Ins Grp# ____________________

Secondary Ins ______________________________ Ins Phone ____________________

Secondary Ins Address ______________________________

Subscriber ____________________ DOB ____________ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Ins ID# ______________________________ Ins Grp# ____________________

OTHER MEDICAL CONTACTS

Primary Care/Physician ______________________________ Phone ____________________

Address ______________________________

Pharmacy ______________________________ Phone ____________________

Address ______________________________

DISCLOSURE OF BENEFITS

I have received a copy of the HIPAA Privacy Notice and authorize release of information concerning my health care, advice and treatment provided for the purpose of evaluating and / or administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the physician.

______________________________ Date ______________

Signature of Patient or Patient Representative

CHIEF COMPLAINT

Name: ______________________________ DOB: ______________________________

Current date: ______________________________

Please answer the questions below:

What are the chief complaints for which you are seeking treatment
Number the complaints with #1 being the most important.

_________ Frequent heavy snoring which affects the sleep of others

_________ Daytime sleepiness

_________ I have been told that I stop breathing

_________ I have trouble falling asleep

_________ Gasping when I wake up

_________ Nighttime choking spells

_________ I feel unrefreshed in the morning

_________ My throat is hoarse in the morning

_________ I frequently have morning headaches

_________ I have swelling in my ankles and/or feet

_________ I grind my teeth

_________ My jaw clicks

_________ Other ________________________

CPAP INTOLERANCE FORM

I have attempted to use the CPAP machine to manage my Obstructive Sleep Apnea but find it intolerable for the following reasons (please check all that apply):

- ☐ I find the device cumbersome and it interrupts my sleep
- ☐ The machine is noisy and negatively impacts my sleep or my bed partner's sleep
- ☐ I am unable to sleep on my back like the CPAP requires
- ☐ I am unable to tell a noticeable difference in my symptoms of sleep apnea when I wear the machine
- ☐ The pressure on my machine is too high
- ☐ I remove my CPAP unknowingly when I am sleeping
- ☐ I feel claustrophobic when I wear the mask
- ☐ I have been unable to find a mask that fits properly
- ☐ The mask leaks
- ☐ The straps or headgear cause me discomfort
- ☐ I refuse to even attempt CPAP
- ☐ If other, please explain: ______________________________

____

____

I have found that I am unable to comply with the CPAP machine as a treatment for my Sleep Apnea. For this reason, I am seeking an alternative treatment method for my condition. I realize that the treatments I am consenting to may help my sleep apnea, but may not completely alleviate it (particularly if my sleep apnea is severe). My physician has advised me of alternative therapies that may be used in conjunction with the treatments I am consenting to today.

____
Patient Name

____
Date

____
Patient Signature

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Patient Name: ______________________

MEDICAL HISTORY

Are you allergic to any medication? If yes, please list below along with a description of the reaction you experienced.

____

____

____

Are there any medications that you are currently taking including over the counter medicines and vitamins? If yes, please list.

____

____

____

Do you have a history of any of the following medical conditions? Please circle.

Condition	Y / N
Anemia	Y / N
Arteriosclerosis	Y / N
Asthma	Y / N
Autoimmune disorders	Y / N
Bleeding	Y / N
Chronic sinus issues	Y / N
Chronic fatigue	Y / N
Congestive heart failure	Y / N
Current pregnancy	Y / N
Diabetes	Y / N
Difficulty concentrating	Y / N
Dizziness	Y / N
Emphysema	Y / N
Epilepsy	Y / N
Fibromyalgia	Y / N
Frequent sore throats	Y / N
Gastroesophageal Reflux (GERD)	Y / N
Hay fever	Y / N
Heart disorder	Y / N
Heart murmur	Y / N
Heart pacemaker	Y / N
Hepatitis	Y / N
Hypertension	Y / N
Immune system disorder	Y / N
Insomnia	Y / N
Jaw joint surgery	Y / N
Memory loss	Y / N
Morning dry mouth	Y / N
Nighttime sweating	Y / N
Osteoporosis	Y / N
Prior orthodontic treatment	Y / N
Rheumatic fever	Y / N
Swollen, stiff or painful joints	Y / N
Tonsillectomy	Y / N
Injury to face, head, mouth, teeth	Y / N
Irregular heart beat	Y / N
Low blood pressure	Y / N
Migraines	Y / N
Muscle spasms or cramps	Y / N
Osteoarthritis	Y / N
Poor circulation	Y / N
Recent excessive weight gain	Y / N
Shortness of breath	Y / N
Thyroid problems	Y / N
Wisdom teeth extraction	Y / N

Patient Name: ______________________________

Have any members of your family (blood relatives) had:

Heart disease	Y / N
High blood pressure	Y / N
Diabetes	Y / N
A sleep disorder	Y / N

How often do you consume alcohol within 2-3 hours of bedtime?

Never | Once a week | Several days a week | Daily | Occasionally

How often do you take sedatives within 2-3 hours of bedtime?

Never | Once a week | Several days a week | Daily | Occasionally

How often do you consume caffeine within 2-3 hours of bedtime?

Never | Once a week | Several days a week | Daily | Occasionally

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Snoring and Sleep Apnea Questionaire

Name ______________________________ Date ____________

Height ____________ Weight ____________ Neck Circumference ____________

Clinical Information (Check all that apply)

☐	Disruptive snoring	☐	Witnessed apnea during sleep
☐	Disturbed or restless sleep	☐	Frequent unexpected arousals from sleep
☐	Non-restorative sleep	☐	Regular sedative / sleep-aid use
☐	Regular alcohol use	☐	Choking / gasping during sleep
☐	Excessive daytime sleepiness	☐	Excessive daytime fatigue

Thornton Snoring Scale

What is your Snore Score? Snoring can be a harmless annoyance or an indication of a more serious sleep disorder. This short quiz can help determine if you may need further evaluation for a sleep condition. *A score of 5 or higher is associated with sleep-disordered breathing.*

Use the following scale to choose the most appropriate number that describes the snoring in your situation:

0 = **Never**
1 = **Infrequently** (1 night per week)
2 = **Frequently** (2-3 nights per week)
3 = **Most of the time** (4 or more nights per week)

Snoring affects my relationship with my partner	
Snoring causes my partner to be irritable or tired	
Snoring requires us to sleep in separate rooms	
The snoring is loud	
Snoring affects other people when I sleep away from home (e.g. hotel)	
TOTAL	

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? Please refer to your recent usual way of life.
Normal 0-10, Borderline 10-12, Abnormal 12-24

Even if you haven't done some of these things recently, please try to work out how they would have affected you if they occurred. Use the following scale to choose the most appropriate number for each situation:

0 = Would **never** doze
1 = **Slight** chance of dozing
2 = **Moderate** chance of dozing
3 = **High** chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total	

Physician Signature: ______________________________ Date ____________