Comprehensive Sleep Center
Adult and Pediatric Sleep Medicine

PATIENT REGISTRATION FORM – PEDIATRIC AGE 2-12

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

SUBCRIBER'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: ______________________________________

COMPREHENSIVE SLEEP CENTER
Adult and Pediatric Sleep Medicine

PEDIATRIC QUESTIONARE

Patient Name: ________________________________ Date of Birth: ______________ Date: _____________

Questionnaire Filled out by: ______________________________________ _______________________
Name *Relationship to Patient*

Please state, in your own words, the reason why you, or your child's physician referred you to our clinic:

____

____

At what age did this problem begin? ______ years ______ months

Has there been a change in this problem? Y N

Describe: ____

CHILD'S BIRTH HISTORY	ANSWER	EXPLANATION
Normal Delivery	Y N	
Premature Delivery	Y N	
Oxygen needed at birth	Y N	
Extended Hospital Stay	Y N	

CHILD'S FAMILY AND SOCIAL HISTORY	ANSWER	
Any Sleep Disorder's in Family History	Y N	Type of Sleep Disorder:
Who has Sleep Disorder		
Is child enrolled in Special Education Class	Y N	
Average Grades in School		
How many members living in home		
Whom does the child reside with		
Anyone smoke in the home	Y N	
Pets living inside the home	Y N	
Daily caffeinated beverage intake	oz	

CURRENT HISTORY		
ASTHMA	CONGESTION	SEIZURES/ EPILEPSY
FREQUENT STREP THROAT	FREQUENT COLDS	FREQUENT EAR INFECTIONS
CHRONIC BRONCHITIS	CARDIAC ISSUES	ACID REFLUX
BIPOLAR/DEPRESSION	ADD/ADHD/ODD	DOWN'S SYNDROME
DELAYED GROWTH	DEVELOPMENTALY DELAYED	ALLERGIES
LEARNING DISABILITY	AUTISM	OTHER

SURGICAL HISTORY	ANSWER	DATE	AGE
TONSILS	Y N		
ADENOIDS	Y N		
OTHER	Y N		

MEDICATIONS: Please indicate all current medications, prescription and over the counter, being taken currently or have taken within the last 30 days:

Medication Name	Dosage Mg	Reason

Does the patient have any medication allergies? Yes _______ No ________ If Yes, indicate below:

Medication Name	Medication Reaction

WHILE SLEEPING MY CHILD		
POOR SLEEPER	CONSTANT SNORING	CHOKING DURING SLEEP
RESTLESS SLEEPER	SNORE LOUD	SNORES
GASPS FOR AIR	BREATHS HEAVY	STRUGGLES TO BREATH
KICKS LEGS WHILE SLEEPING	GRINDS TEETH	PAUSES IN BREATHING
ROCKS WHILE SLEEPING	BANGS HEAD	GETS OUT OF BED
LOOKS PALE OR BLUE	NIGHTMARES	COMPLAINS OF ACHY LEGS
SWEATS	SLEEP WALKS	SLEEP TALKS

Childs Sleep Schedule	Weekdays	AM/PM	Weekends	AM/PM
Usual Bedtime				
Usual Awakening Time				
Time it takes to fall asleep	Min			
Nightly Awakenings				
Duration of Awakenings	Min			
Nap	Y N			
How many naps				
Nap Time				
Is there a scheduled bedtime routine	Y N			
Have own bedroom	Y N			
Have their own bed	Y N			
Resist going to bed	Y N			
Difficulties falling asleep	Y N			

Complete the statement by placing an "X" in the column that best describes your child	Own Room Own Bed	Sibling's Room Own Bed	Sibling's Room Siblings Bed	Parents' Room Own Bed	Parent's Room Parent's Bed
My child usually falls asleep					
My child usually sleep					
In the morning my child wakes					

Circle All Statements that Apply When Waking		
Difficulties Getting Out of Bed	Lack of Appetite	Morning Headaches
Bedsheets Disorganized	Morning Grogginess	Difficulty Awakening

Write **YES** if the statement applies **DURING THE DAY**	**YES/NO**
Breath through the nose	
Problems swallowing	
Reports unable to move when falling asleep or upon awakening	
Becomes weak/loss of muscle tone when excited, angry or laughing (jaw dropping, knee buckling, falling on the floor, difficulty talking) for 1 – 2 minutes	
Is "on the go", acts as if driven by a motor	
Sleepy during the day	

FOR CHILDREN 5 YEARS OF AGE AND OLDER: (check all which apply)					
Complains of feeling tired		Becomes easily upset		Seems very sensitive	
Has trouble getting dressed		Falls asleep in school		Seems excessively anxious	
Seems hyperactive		Falls asleep in odd situations or places		Has difficulty making close friends	
Impulsive		Does more poorly than expected		Has problems with attention	
Behavioral problems		Learning problems			

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.

Cancelation: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $50 charge for Clinic appointments and $175 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