COMPREHENSIVE SLEEP CENTER
3515 Coolidge Rd Suite A
East Lansing, MI 48823
PHONE: 517-755-6888
FAX: 517-657-7759

PATIENT REGISTRATION FORM

First Name: _____ Middle Name: _____
Last Name: _____ Preferred Name: _____

Address: _____
_____

DEMOGRAPHIC INFORMATION

Social Security#: _____ Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ White ☐ American Indian ☐ Asian ☐ Black or African American
☐ Native Hawaiian or another Pacific Islander ☐ Other: _____
☐ Declined to specify

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
☐ Unknown ☐ Other: _____ ☐ Declined to specify

EMPLOYMENT INFORMATION

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Employer Name: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

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NEW PATIENT INTAKE – ADULT 18 AND OLDER

Patient Name: _____ Date of Birth: ___ / ___ /_____

Current Medications, if any:

Medication Name	Dose/Strength	Frequency

Any known drug allergies: ____ Yes ____ No. If Yes, please describe:

Medication Name	Reaction

Family Medical History (immediate family only; mom, dad, grandpa, grandpa [paternal/maternal]):

Family Member	Condition (sleep apnea, stroke, diabetes, heart attack)

Substance/Tobacco Use

Do you or have you ever smoked tobacco? __ Yes __ No. If yes, current __ or former __?
Any other forms of tobacco/nicotine? __ Yes __ No. If yes, what? _____
Do you use any illicit or recreational drugs? __ Yes __ No. If yes, what? _____
Alcohol intake? _____ glasses before bed. Caffeine intake? _____ glasses before bed.

Social History/Sleeping Habits:

In your own words, briefly explain why you've been referred? _____
_____
Have you ever been previously treated or evaluated for a sleep disorder? __ Yes __ No. If yes, please explain: _____
_____
Are you a shift worker? (circle) Yes or No. Normal Work Hours: _____
Weekday Bedtime: _____ AM /PM. Weekend Bedtime: _____ AM /PM.
Weekday Wake time: ____ AM /PM. Weekend Wake time: ____ AM/PM
How long does it take you to fall asleep? _____

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Awaken throughout night? __Yes __ No. If Yes, How many times? _____ How long? _____
Do you take naps? ___ Yes ___ No. If yes, How many weekly? _____ How long? _____
Do you use electronics at night/bedtime/in bed? __ Yes __ No. If yes, how long? _____
Do you leave any items (such as, light, nightlight, tv, music, fan) on while sleeping? __ Yes__ No
If yes, what items? _____
Do you have difficulty breathing at night? __ Yes __ No.
Currently on CPAP/BiPAP? __ Yes __ No. If yes, current DME supplier? _____
Have you tried any medications (prescription or OTC) to help with sleep? __ Yes __ No. If yes, please list:_____

Please answer Yes or No to the following:

	Y	N		Y	N
Regular Bed Partner			Restlessness of Legs (crawling/twitching)		
Bed partner complains you snore			Does this get better with movement?		
Been told you stop breathing in sleep			Racing thoughts when trying to sleep?		
Fall asleep when you don't mean to			Does this affect your sleep?		
Awake in the morning with headache			Any pain or discomfort when sleeping		
Awake in the morning with dry mouth			Ever feel down, depressed or hopeless		
Feel tired during the day			Feel paralyzed when awakening or falling asleep		
Feel rested or refreshed after sleep			Sudden muscle weakness, jaw dropping, knee buckling, falling, or difficulty talking for 1-2 minutes when becoming emotional		
Wake up too early, unable to fall asleep					

Patient's Medical History (Past and Present) Circle all the apply

Abuse/Domestic Violence	Bipolar/Depression	Hypertension
ADD/ADHD	Cardiac Issues	Headaches/Migraines
Asthma	Cancer; Type: _____	Hepatitis
Acid Reflux/GERD	Congestive Heart Failure	Mental Illness: _____
AIDS/HIV	Coronary Artery Disease	Obesity
Allergies	Diabestes: Type 1 or Type 2	Osteoporosis
Anxiety Disorder	Difficulty Swallowing	Pulmonary Embolism
Bedwetting	Down's Syndrome	Seizure/Epilepsy
Bladder or Kidney Problems	Fibromyalgia	Stroke
Other:		

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Surgical/Vaccine History

Have you ever had any previous Ear, Nose and Throat surgeries? ___ Yes ___ No

Tonsillectomy: _____ year

Adenoids: _____ year

Nasal Septum/Polyps removed: _____ year

Any other surgeries related to respiratory? ___ Yes ___ No. If yes, please describe: _____

_____

Received any vaccines: ___ Yes ___ No. If yes, please list:

Vaccine: _____ When: _____ year

Vaccine: _____ When: _____ year

Vaccine: _____ When: _____ year

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone: _____

Primary Care Provider

Provider Office: _____

Provider Name: _____

Provider Address: _____

_____

Provider Phone: _____ Fax: _____

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Financial Policy and Consent

PLEASE NOTE: Copays and Deductibles are due at the time of service. We accept personal checks, cash and most major credit cards. (We do not accept Apple Pay, PayPal, Venmo, or any other virtual form on currency).

Not all services are covered benefits in all insurance policies. As a courtesy, we verify your benefits to let you know if there will be any out-of-pocket expenses for you such as deductible, coinsurance and copays. If there are any charges due, those will be collected prior to services being rendered. If you are unable to pay, we may need to reschedule your appointment.

Payment Options:

Self-Pay/Uninsured Patients: We offer a discounted rate for cash paying patients. You are expected to pay the full amount for services prior to services being rendered. If we are out of network or your policy does not cover services, you will be considered self-pay.

HSA/FSA Payment Cards: If you have a Health Savings Account or Flex Spending Account, we typically do not collect charges up front. However, we may require that your card be saved on file to pay for services once claims have been processed by insurance.

Prepayment/Payment Plans: We do offer payment plans on large balances and pre-payment plans for upcoming services. However, we do require a percentage down (depending on the amount) and will need to be paid in full before services can be rendered.

> **We also accept Care Credit as a form of payment for services. Please ask to speak to the Billing Manager if you are interested in Care Credit.**

Cancellation Policy: We understand life happens; We request that you please give advanced notice if you are going to be late or need to cancel/reschedule an clinic appointments.
Sleep Studies – we require a 24 hour notice for cancellation or rescheduling, otherwise there is a $175 fee.

Returned checks will have a $35 fee. Printed Medical Records 25 pages and up is $25.00.

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

_____ _____

Printed Name of Patient/Responsible Party Date

_____

Signature