



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 – PEDIATRICS 6 AND UNDER**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Pediatrician: \_\_\_\_\_ PH: \_\_\_\_\_

Current Medications, if any:

Medication Name	Dose/Strength	Frequency

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

Medication Name	Reaction

Vaccines: \_\_\_\_ Yes \_\_\_\_ No. If yes, please list: \_\_\_\_\_

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

Family Member	Condition

### **Social History:**

With whom does child reside? \_\_\_\_\_

How many people in household? \_\_\_\_\_ Any pets in home? \_\_\_\_ Yes, \_\_\_\_ No

Passive Smoke Exposure: \_\_\_\_ Yes, \_\_\_\_ No. Does anyone smoke in the home? \_\_\_\_ Yes, \_\_\_\_ No.

### **Sleep Schedule:**

Weekday Bedtime: \_\_\_\_\_ AM /PM. Weekend Bedtime: \_\_\_\_\_ AM /PM.

Weekday Wake time: \_\_\_\_\_ AM /PM. Weekend Wake time: \_\_\_\_\_ AM/PM.

Does patient sleep in own room? \_\_ Yes \_\_ No. If no, where? \_\_\_\_\_

How long does it take to fall asleep? \_\_\_\_\_

Awaken throughout night? \_\_ Yes \_\_ No. If Yes, How many times? \_\_\_\_\_

Is there a scheduled bedtime routine? \_\_ Yes \_\_ No

How many naps a day? \_\_\_\_\_ How Long? \_\_\_\_\_



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**Please check all that apply:**

Snoring		Stops Breathing		Daytime Sleepiness		Teeth Grinding	
Bedwetting		Morning Grogginess		Mouth Breathing		Head banging	
Sleepwalking/Talking		Sleep Paralysis		Acting out dreams		Turns Blue/Pale	
Restless Legs		Resists Going to Bed		Difficulty Falling Asleep		Nightmares	
Nasal Breather		Problems Swallowing		Difficulty Waking Up		"On the go"	

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

Asthma	Allergies	Acid Reflux/GERD
ADD/ADHD	Autism	Bipolar/Depression
Behavioral Disorder	Cardiac Issues	Chronic Bronchitis
Congestion	Cancer	Delayed Growth
Down's Syndrome	Frequent Colds	Frequent Ear Infections
Frequent Strep Throat	Learning Disability	Other:

**Surgical History:**

Tonsils Removed: \_\_\_\_ Yes \_\_\_\_ No. If yes, When? \_\_\_\_\_

Adenoids Removed: \_\_\_\_ Yes \_\_\_\_ No. If yes, When? \_\_\_\_\_

Other: \_\_\_\_\_. When? \_\_\_\_\_

**Form Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_



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## Financial Policy and Consent

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**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 a clinic appointment.

***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.

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Printed Name of Patient/Responsible Party

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Date

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Signature