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 7 THROUGH 12 YEARS

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

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

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.
Average Grades in school: _____ Enrolled in Special Education classes? ___ Yes ___ No.
Does more poorly than expected? ___ Yes ___ No. Daily Caffeine Intake: _____ oz

Sleep Habits/Environment:

School Night Bedtime: _____ AM /PM. Weekend Bedtime: _____ AM /PM.
School Day 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. Does patient take naps? ___ Yes ___ No.
If yes, how long? _____.
Does your child use electronics at night/bedtime/in bed? __ Yes __ No. If yes, how long? _____

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Please check all that apply:

Snoring		Stops Breathing		Teeth Grinding		Seems Anxious	
Bedwetting		Mouth Breathing		Sleepwalking/Talking		Head banging	
Restless Legs		Resists Going to Bed		Acting our dreams		Difficulty getting out of bed when waking	
Turns Pale/Blue		Nightmares		Difficulty Falling Asleep			
Nasal Breather		Problems Swallowing		Seems Hyperactive		Impulsive	
Easily Upset		Falls asleep at school		Behavioral Problems		Restless Sleeper	
Choking		Daytime sleepiness		Problems with Attention		Seems Sensitive	

Does your child complain about any of the following:

Morning headaches:___ Yes ___ No Morning grogginess: ___ Yes ___ No
Achy/Sore Legs: ___ Yes ___ No Bedsheets Disorganized: ___Yes ___ No
Lack of Appetite: ___ Yes ___ No
Unable to move when falling asleep/awakening: ___ Yes ___ No
Becomes weak/loss of muscle tone when excited, angry or laughing (such as jaw dropping, knee buckling, falling on the floor or difficulty talking) for 1 – 2 minutes: ___ Yes ___ No.

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

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

In your own words, briefly describe why you've been referred: _____
_____

Any previous sleep testing? ___ Yes ___ No. If yes, where and when? _____
_____

Form Completed By: _____ Date: _____
Relationship to patient: _____

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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 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.

_____ _____

Printed Name of Patient/Responsible Party Date

_____

Signature