FACILITY NAME: _____ (to be completed by the Sleep Technologist)

PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #
Responsible Party Drivers License # State: Number		Occupation	How Long at current Employer?
Name of employer Address **or** ___ **Not Applicable**		Business Phone	Occupation
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Ye **[ ]** No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Workers' Compensation? Yes **[ ]** No **[ ]** Motor Vehicle? Yes **[ ]** No **[ ]** **If Yes-put W/C or MVA carrier below**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Group #			Policy #	Group #

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to _____ for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patient Rights and Responsibilities and this facility's Grievance Procedure.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

√ SLEEP STUDY – Additional Information may be obtain by call (877) SLEEP-90 or by calling h clinic directly.

FACILITY NAME: _____ (to be completed by the Sleep Technologist)

MEDICAL HISTORY FORM – Please complete prior to your first sleep study

Patient Name: _____
Date of Birth: _____ Date of Service: _____

New Patient Visit

1. Describe your sleep problem: _____

_____

_____

2. When did your sleep problem begin: _____(month/year)

3. Current Medications: (attach a list if you have)

Medication	Dose/Frequency	Last Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have you ever had a sleep study performed? _____Yes _____No
If 'Yes', where and what were the results?

_____
_____
_____

5. My occupation is: _____
My job requires shift work ____Yes ____ No My work hours are: _____

6. I have actually fallen asleep while driving a car. ____ Yes ____ No
If yes, how often? _____ times.

Please consult your bed partner when answering the following questions.

7. I snore ____Nightly ____ Weekly ____ Rarely ____ Never

8. I snore in all sleep positions: ____ Yes ____ No

9. My snoring has been described as ____ Mild ____ Moderate ____ Loud

10. I stop breathing at night: ____ Yes ____ No

11. Please complete the following information for all physicians/healthcare providers you have seen within the past 5 years starting with your primary physician.

Name	City	Specialty	Send Summary to this Doctor	
			❑ Yes	❑ No
			❑ Yes	❑ No
			❑ Yes	❑ No
			❑ Yes	❑ No
			❑ Yes	❑ No

√ SLEEP STUDY – Additional Information may be obtain by call (877) SLEEP-90 or by calling h clinic directly.

FACILITY NAME: _____ (to be completed by the Sleep Technologist)

I authorize Qualcare Therapy Center and it's employee to forward my medical information to those persons marked "yes" above, and other healthcare providers who may be responsible for my continuing medical care.

12. Indicate whether you have ever had any of the following and if so, please describe:

Abnormal swelling in legs or feet	❑ Yes	❑ No
Pain in calves when you walk	❑ Yes	❑ No
Awakening at night short of Breath	❑ Yes	❑ No
Arthritis and Rheumatism	❑ Yes	❑ No
AID or HIV	❑ Yes	❑ No
Blackouts or loss of consciousness	❑ Yes	❑ No
Cardiac Arrhythmias	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No
Congestive heart failure	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Hiatal hernia or reflux esophagitis	❑ Yes	❑ No
High blood pressure	❑ Yes	❑ No
Heart attach	❑ Yes	❑ No
High/Low blood sugar	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No
Pain, Stiffness or swelling in back, muscles	❑ Yes	❑ No
Problems falling asleep, staying asleep	❑ Yes	❑ No
Rapid or irregular heart beats	❑ Yes	❑ No
Thyroid disease	❑ Yes	❑ No
Significant Headaches	❑ Yes	❑ No
Skin rash	❑ Yes	❑ No
Daytime Sleepiness	❑ Yes	❑ No
Sleep Apnea, Snoring	❑ Yes	❑ No
Weight loss or gain of more than 100 lbs.	❑ Yes	❑ No

Describe: _____

_____

Patient Signature: _____

Print Name: _____

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