SLEEP MEDICINE ASSOCIATES OF NEW YORK CITY, PLLC

11 East 26th Street, 13th Floor
New York, NY 10010

Telephone: 212 481-1818
Facsimile: 212 523-0498

PATIENT REGISTRATION

Dr.☐ Mr.☐ Ms.☐ Mrs.☐ Patient name: _____ Sex: M☐ F☐

Social Security # _____-_____-_____ Date of Birth: _____ / _____ / _____

Street: _____ City: _____ State:____ Zip:_____

Home phone (___) _____ Cell Phone (___) _____

E-Mail _____ Pager (___) _____

Marital status: Married ☐ Single ☐ Divorced ☐

EMPLOYER or WORK INFORMATION

Employer: _____ Retired ☐ Date: _____

Street: _____ Business Phone:(___) _____ ext._____

City:_____ State: _____ Zip:_____ Occupation: _____

INSURANCE INFORMATION

Card available yes ☐ no ☐ Copay paid: cash ☐ check ☐ credit card ☐ bill ☐

Primary Insurance Carrier: _____

ID# _____ Group # _____

Primary Card Holder: _____ DOB: _____

Secondary Insurance Carrier:

_____

ID# _____ Group # _____

EMERGENCY CONTACT

Name: _____ Phone: _____

I hereby authorize Sleep Medicine Associates of NYC, and it's physicians to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to Sleep Medicine Associates of NYC and it's physicians. I understand that I am responsible for any or part of the charges that are not covered by medical coverage.

Signed: _____ Date: _____

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REFERRING PHYSICIAN

Name: _____ Specialty: _____

Address:

_____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

Is this physician your primary doctor? Yes ☐ No ☐

Name of primary doctor if not the same as above:

Name: _____ Specialty: _____

Address:

_____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

Please name other physicians whom you would like to have your sleep report sent to:

Name: _____ Specialty: _____

Address:

_____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

Name: _____ Specialty: _____

Address:

_____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

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SLEEP HISTORY QUESTIONNAIRE

Patient Name: _____

Date: _____

Please check the appropriate box or give short answers for the following:

		Yes	No
1.	Do you feel sleepy or have "sleep attacks" during the day?	☐	☐
2.	Do you nap during the day?	☐	☐
3.	Do you have trouble concentrating during the day?	☐	☐
4.	Do you have trouble falling asleep when you first go to bed?	☐	☐
5.	Do you awaken during the night?	☐	☐
6.	Do you awaken more than once?	☐	☐
7.	Do you awaken too early in the morning?	☐	☐
8.	Do you snore?	☐	☐

9. How long have you had trouble sleeping? What do you think precipitated the problem?

_____
_____

10. How would you describe your usual night's sleep (hours of sleep, quality of sleep, etc.)

_____

11.	Do others live at home who interrupt your sleep?	☐	☐
12.	Are you regularly awakened at night by pain or the need to use the bathroom?	☐	☐
13.	Does your job require shift changes or travel?	☐	☐
14.	Do you drink caffeinated beverages? (Coffee, tea, or soft drinks)	☐	☐
15.	Have you ever suffered from depression, anxiety, or similar problems?	☐	☐

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16. Apart from difficulty sleeping, what, if any other medical problems do you have?

_____

_____

17. What sleep medications, prescription or nonprescription, do you take? (Please include the dose, how often you take it, and for how many months/years you have taken it.)

_____

All other medications:

_____

_____

18. What other prescription and over- the- counter medications do you regularly use? (Again, please include the dose, frequency and duration.)

_____

QUESTIONS FOR THE SLEEP PARTNER

		Yes	No
1.	Does your sleep partner snore?	☐	☐
2.	Does your sleep partner seem to stop breathing repeatedly during the night?	☐	☐
3.	Does your sleep partner jerk his or her legs or kick you while he or she is sleeping?	☐	☐
4.	Have you ever experienced trouble sleeping? Please explain:	☐	☐

_____

_____

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EPWORTH SLEEPINESS SCALE

Name: _____ Your Sex: M ☐ F ☐

Today's date: _____ Your age (years): _____

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done dome of these things recently try to work out how they would have affected you.

Please CHECK the most appropriate number for each situation:

	Never	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
A. Sitting and Reading	0 ☐	1 ☐	2 ☐	3 ☐
B. Watching TV	0 ☐	1 ☐	2 ☐	3 ☐
C. Sitting inactive in a public place; e.g. a theatre or a meeting	0 ☐	1 ☐	2 ☐	3 ☐
D. As a passenger in a car for an hour without a break	0 ☐	1 ☐	2 ☐	3 ☐
E. Lying Down to rest in the afternoon when circumstances permit	0 ☐	1 ☐	2 ☐	3 ☐
F. Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
G. Sitting quietly after a lunch without alcohol	0 ☐	1 ☐	2 ☐	3 ☐
H. In a car while stopped for a few minutes in traffic	0 ☐	1 ☐	2 ☐	3 ☐