Sleep Associates of Connecticut
the sound sleep center

Michael Imevbore, MD FCCP
Pulmonary Critical Care
and Sleep Medicine

West Haven • 203.909.6950
687 Campbell Avenue West Haven, CT 06516

Hamden • 475.202.6512
2543 Dixwell Avenue Hamden, CT 06514

Patient Registration Form

Please print neatly and fill out all areas completely

PATIENT INFORMATION Date:_____

Name: _____
Last First Middle

Address:_____

_____
City State Zip Code

Home Phone (_____)_____ **Cell Phone** (_____)_____
Fax Number (_____)_____ Email address: _____

Secondary or Winter Address:_____
P.O. Box _____
City State Zip Code
Secondary Phone (_____)_____ Cell Phone (_____)_____

Date of Birth: ____/____/____ **Age**:_____ **Sex**: Male / Female

Social Security Number: _____-_____-_____

Race: Caucasian / African American / Hispanic / Indian / Asian / Native American / Other: _____

Marital Status: Single / Married / Divorced / Widowed / Partner

Spouse/Partner Name: _____

Party to contact in case of emergency other than spouse or partner:
Name: _____ Phone (_____)_____
Relationship to patient: _____

Pharmacy: _____ City/State_____
Phone: _____

Primary Care Physician: _____ Phone (_____)_____

Address: _____

Referring Physician: _____ Phone (_____)_____

Address: _____

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EMPLOYMENT INFORMATION

Retired: Yes_____ No_____ Spouse Retired: Yes_____ No_____
Name of Employer: _____
Employer's Address: _____
Work # (_____)_____ Ext:_____ Occupation:_____

Spouse's Employer: _____
Employer's Address: _____
Work # (_____)_____ Ext:_____ Occupation:_____

INSURANCE INFORMATION

Please Present Insurance Card at Each Visit

PRIMARY HEALTH INSURANCE
Insurance Name_____
Name of Subscriber_____
Date of Birth _____/_____/_____
SS# _____-_____-_____
Policy # _____
Relationship to patient _____

SECONDARY HEALTH INSURANCE
Insurance Name_____
Name of Subscriber_____
Date of Birth _____/_____/_____
SS# _____-_____-_____
Policy #_____
Relationship to patient _____

WORKER'S COMPENSATION

Is this a worker's compensation injury or illness? Yes _____ No_____
Date of injury: _____/_____/_____ Claim # _____
Worker's Compensation Carrier's Name: _____
Address: _____
Phone # (_____)_____ Ext_____ Contact person: _____

As a courtesy to our patients, we will file all necessary information to your carrier for reimbursement. We will allow 120 days from the filing date. If we do not receive anything after 120 days, you will be responsible for all charges.

STATEMENT OF FINANCIAL RESPONSIBILITY

Please Read Before Signing:
All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. Insurance companies and our office require that co-payments are paid at the time of service. **If the patient co-pay is not paid at the time of service, there will be an additional $25 fee.** If state assistance, member must be eligible for services for that date. If no insurance, it is customary to pay for services when rendered unless other arrangements have been made in advance. I am responsible to inform Connecticut Pulmonary Specialists, PC of any insurance changes. I hereby assign Connecticut Pulmonary Specialists, PC all payments from the above insurances for medical services rendered to the patient. If I have no insurance, I am directly responsible for payment. I authorize the disclosure of my medical records and/or diagnosis by my physician, health professional, insurance company and any third party payers when necessary. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE CONTRACT, OR APPLIED TO MY DEDUCTIBLE.**

Signature:_____ Date: _____

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CANCELLATION FEE AGREEMENT

Sleep Associates of Connecticut and **Connecticut Pulmonary Specialist** have an appointment protocol in place about appointment cancellation.

You have 48 hours before the date of your appointment to cancel, otherwise, you will be charged $50 for an office visit and $200 for a Sleep Study **cancellation or no show.**

Patient Signature_____ **Date**_____

PATIENT'S SLEEP HISTORY QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Please answer the following by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night For how many months/years? _____

❑ Being sleepy all day For how many months/years? _____

❑ Snoring For how many months/years? _____

❑ Unwanted behaviors during sleep, explain _____

❑ Other, explain _____

Sleep Pattern:	Work Days (Weekday)	Off Days (Weekends)
Typical bedtime:	_____ a.m./p.m.	_____ a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., eat, watch TV:	_____	_____
Typical amount of time to fall back asleep:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____ a.m./p.m.
Desired wake up time:	_____ a.m./p.m.	_____ a.m./p.m.
How do you usually awaken, e.g. alarm clock?:	_____	_____
Typical time you get out of bed:	_____ a.m./p.m.	_____ a.m./p.m.
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____

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Please check all of the following statements that are true about your sleep:

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

Restlessness

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

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Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: ___cups/bottles/cans per day

Habits

Do you smoke? ❑ Yes ❑ No

If Yes:	What?	Amount per Day	For How Many Years
	❑Cigarettes	_____ pack(s)	_____ years
	❑Cigars	_____ cigars	_____ years
	❑Tobacco	_____ pipes	_____ years

Do you drink alcohol? ❑ Yes ❑ No

If Yes:	What?	Frequency			Amount per Week
	❑Beer	❑Daily	❑Weekends	❑Rare	_____ cans/week
	❑Wine	❑Daily	❑Weekends	❑Rare	_____ glasses/week
	❑Liquor	❑Daily	❑Weekends	❑Rare	_____ shots/week

Social History

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Employment Status: ❑Employed ❑Unemployed ❑Retired

- ❑ My job requires driving a vehicle
- ❑ I work with dangerous equipment or substances
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker
- ❑ I am currently a student

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Medical History (list any medical problems you have been diagnosed with by a medical professional)

Family History of sleep disorders

Surgical history

Social History

1. Do you Smoking? If so how much? How long have you smoked?
2. Do you use alcohol ? If so How Much?
3. Marital Status / Children
4. Occupation
5. With whom do you live?

Current medications

Allergies

Review of Systems (Circle any current symptoms or issues below)

Constitutional – Weight loss.....weight gain....increased appetite....decreased appetite

Eyes – Vision loss...blurry vision...

Ears/Nose/Mouth/Throat – Hoarseness... dry throat... enlarged tonsils...loss of hearing...nasal congestion...runny nose...dental problems

Cardiovascular – Chest pain...High blood pressure...heart murmur...heart failure...arrhythmia

Respiratory- asthma…bronchitis…pneumonia…cough…shortness of breath…wheeze

Genitourinary –kidney disease…incontinence

Musculoskeletal – joint or back pain…muscle weakness…muscle cramps or spasm or pain

Neurologic – headaches…loss of sensation or tingling…weakness…dizziness

Psychiatric – Depression…anxiety or panic attacks…mania…hearing voices

Endocri ne- thyroid disease…high blood sugar…low testosterone…hormone disturbances

Hematologic – Anemia…low iron…

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theater or meeting)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____
Total	_____

Reference: Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991;14:540-5.

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