TREASURE COAST SLEEP DISORDERS, LLC
[Please use black ink to complete]
Patient Information Sheet

Name _____ Date _____
First Middle Last

Address _____

_____

SSN: _____ Gender M F

Date of Birth: _____ Age: _____ Height: _____ Weight _____

Phone Number: Preferred number for us to call you: Please circle one: Home Cellular Work

Home: _____ Cell: _____ Work: _____

-Emergency Contact(s) Information-

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Referring Physician: _____

Occupation: _____ Marital Status: S M D W

Insurance

Insurance Name: _____ Secondary: _____

Policy #: _____ Policy #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Treasure Coast Sleep Disorders, LLC. I understand that I am financially responsible for any Co-pays, Coinsurance, Deductibles and any balances. Payments under $10.00 must be paid by cash or check, not by credit card. I am responsible for fees that are applied to my account, if it is sent to a collections agency this includes any cancellation fees. There may be an additional charge from the interpreting physician that may be billed separately. I also authorize the release of any medical or financial information necessary to process claims related to diagnostics/treatment to the Healthcare Financial Administration and its counterparts.

Signature: _____ Date:_____

Sleep History Questionnaire
[Please use black ink to complete]

Name _____ Date _____
First Middle Last

Medications:

Name	Amount	How often	Reason

1. **Describe the main problem in your own words that you are currently having and why you think you might have this problem.**

_____
_____
_____
_____
_____

2. **How often does this problem occur?**

( ) Frequently
( ) Sometimes
( ) Irregularly

3. How do you describe your sleep problems? Check all that may apply.

( ) Difficulty falling asleep
( ) Waking up early in the morning
( ) Difficulty awakening
( ) Middle of the night awaking
( ) Excessive daytime sleepiness

4. Have you received treatment for your problem?
( ) YES If so, What type _____
( ) NO
( ) NA

5. How many hours of sleep do you typically get? _____

6. How many times a night do you get up? _____

7. When you awake do you have any pains?
( ) YES If so, What type?
_____
_____
( ) NO

8. Do leg movements or body movements seem to awaken you during the night?
( ) YES- Explain
_____
_____

9. Have you been told/or that you know you: (Check all the apply)
( ) Snore loud
( ) Gasp for air while sleeping
( ) Choke while sleeping
( ) Stop breathing while sleeping
( ) Sweat excessively at night
( ) Body jerking
( ) Sleep Walk

10. Does your problem effect your: (Check all that apply)
( ) Sex life
( ) Work life
( ) Social life
( ) Driving
( ) Energy

11. Do you do the following? (Check all that apply)
( ) Watch TV in bed
( ) Take naps during the afternoon
( ) Read before bed
( ) Consume caffeine ( ) NO
If Yes, What? _____How many? _____

12. With whom do you live with?

_____

13. Do your sleep habits change from during the WEEKDAYS to the WEEKENDS?
( ) YES- Explain

_____

_____

( ) NO

14. Is your sleep disturbed by the following? : (Check all that apply)
( ) Heat
( ) Cold
( ) Noise
( ) Light
( ) Bed partner
( ) Animals
( ) Night time urination; How often? _____

15. What time do you usually go to sleep? _____

16. What time do you usually wake up in the morning? _____

17. Do any of your family members have any type of sleep condition?
( ) YES- Who & what type _____
( ) NO

18. If you work, what is your work schedule?

_____	_____	_____	_____	_____	_____	_____
M	**T**	**W**	**TH**	**F**	**S**	**SUN**

The Epworth Sleepiness Scale

Please answer the questions using the scale given, on how likely are you to doze off. This refers to your current or past situations and how they have affected you.

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

Situation	***Chance of Dozing***
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (example: movies, a park)	_____
As a passenger in a car for an hour without a break	_____
Lying down in the afternoon to rest	_____
Sitting and talking to someone	_____
Sitting quietly after a meal without alcohol	_____
In a car stopped for a few minutes in traffic	_____

Treasure Coast Sleep Disorders, LLC

1380 N.W. Federal Hwy. 188 N.W. Central Park Plaza
Stuart, FL. 34994 Port Saint Lucie, FL. 34986
Ph: 772-232-9990 * Fax: 772-232-9989 * Ph: 772-336-2770

Authorization for Release of Protected Health Information

I: _____ (Print)
Last First Middle

Authorize the below person:

_____(Print)
Last First Middle

___This authorization shall be valid between the dates of _____ to _____

___Indefinite, no date range.

To discuss on my behalf: (Check all that apply)

( ) Medical Billing (example: Collections, Money owed, Money Paid)

( ) Records (example: Test results, appointments, copy of records)

This authorization will be valid indefinitely until notified otherwise by the above said patient.

_____ _____
Patient Signature Date of Birth