COLORADO
SLEEP
INSTITUTE

Comprehensive Care for Sleep Disorders

Patient Registration & Sleep Questionnaire

Patient Information		
Date:	DOB:	
Full name:		
Full address:		
Home phone:	Work phone:	Mobile phone:
Contact preference (circle): home work mobile		
Email address (we do not share or sell your email address):		
Emergency contact:		
Relationship:	Emergency Contact Phone:	

Primary Insurance Information	
Insurance name:	Policy #:
Group:	Insurance Address:
Insurance Phone:	Policy Holder Name:
Relationship:	Policy Holder DOB:
Secondary Insurance Information	
Insurance name:	Policy #:
Group:	Insurance Address:
Insurance Phone:	Policy Holder Name:
Relationship:	Policy Holder DOB:

So that we may effectively communicate with your other providers, please complete:		
Referring physician name:	**Phone:**	**Fax:**
PCP name:	**Phone:**	**Fax:**
How did you hear about us (circle)? Advertising PCP Specialist Physician Word of mouth Patient in practice Hospital Insurance company Other:		

General Sleep Questions	Describe
Describe sleep problems you may have (what brings you to see us?)	
How satisfied are you with your sleep?	**Circle one: 1.....2.....3.....4.....5.....6.....7.....8.....9.....10 (unsatisfied)……………………………………………(satisfied)**
If not a "10", why not?	
How long has sleep been a problem?	
Ever had a sleep study? ❑Yes ❑No	If **yes**, please complete the attached Release of Medical Information so that we may obtain a copy

Insomnia History	Describe
Time you usually get into bed?	
How long to fall asleep at bedtime?	
Time you usually fall asleep?	
Time usually awaken for the day?	
Do you awaken too early for the day?	
Do you sleep through the night?	
How often have trouble sleeping?	
Estimated hours of sleep daily?	
Ever used sleeping pill? Which ones?	

Circadian History	Describe
Latest you sleep in on weekends?	
Sleep/snooze through alarm clocks?	
What is your routine 1hr before bed?	
Use TV, iPad, mobile phone, e-book, or electronics in your bedroom?	
Travel frequently across time zones?	
Ever work the night shift?	

Hypersomnia History	**Describe**
Please measure your sleepiness on a typical day:	**Circle one: 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10** **(none).. (high)**
Awaken refreshed in the morning?	
Ever drowsy when driving?	
Sleepiness affect your functioning?	
Do you nap? Doze off in recliner?	
Do you get weak knees or a slack jaw when genuinely laughing?	
Sleep-Breathing History	**Describe**
Use oxygen, CPAP, or oral appliance?	
Ever told you had low oxygen?	
Have you *ever* been told you snore?	
Told you stop breathing in sleep?	
Headaches when you awaken?	
Sleep on sides, back, or both?	
Live at elevation >6000 feet?	

Sleep-Movements History	**Describe**
Grind your teeth during sleep?	
Have a night-guard for bruxism?	
Legs uncomfortable at night?	
Urge to move your legs at night?	
Leg movements during sleep?	
History of anemia?	

Parasomnias History	**Describe**
Nightmares or night terrors?	
Sleepwalking? Sleep-eating?	
Act out your dreams at night?	
Ever had a seizure?	

Review of Systems	Yes	No	Describe
Weight changes?			
Vision changes?			
Sore throat?			
Short of breath?			
Chest pain?			
Heartburn?			
Urinate at night?			
Pain at night?			
Headaches?			
Depression/anxiety?			
Rash?			
Thyroid problems?			
Donate Blood?			
Nasal allergies?			

Medical History	Yes	No	Describe
Heartburn, GERD, or Reflux?			
Diabetes?			
Heart Disease?			
Heart attack?			
Congestive heart failure?			
Arrhythmias?			
Peripheral vascular disease?			
Stroke?			
High Blood pressure?			
Kidney disease?			
Cancer?			
Depression?			
Anxiety disorder?			
PTSD?			
Thyroid problems?			
Asthma?			
Psychiatric hospitalization?			

List any other medical conditions or medical issues you have had below:

Surgical History	**Yes**	**No**	**Describe**
Tonsillectomy?			
Nasal surgery?			
Thyroid surgery?			
Cardiac surgery or stent?			
Carotid surgery?			
List other surgeries below:			

I am not allergic to any medications:	**True**	**False**

Allergies: list any allergies to medications, foods, etc.	
Name of medication or allergen:	Describe your allergic response:
1)	
2)	
3)	

Medications: list your current medications including "over-the-counter" medications			
Name of Medication:	Dose:	When taken:	Reason for taking:
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Family History	Mother	Father	Brother	Sister	Other
Diabetes?					
Heart Disease?					
Sleep Disorders?					
High blood pressure?					
Stroke?					
Psychiatric Disorders?					
Dementia?					

Social History
Occupation:
Marital status: Single Married Divorced Widowed
Number of children: Do they sleep in your room? Yes No
Do your pets sleep in your room? Yes No
Have a bed partner? Yes No
Describe your daily diet:
Do you exercise? Yes No Describe:
Tobacco use: never when did you quit? Type: cigarettes cigar dip
Alcohol use: never daily weekly monthly rarely special occasions
Consume: none beer wine liquor
Caffeine use: none coffee tea soda energy drinks caffeine pills
Recreational Drugs: none marijuana amphetamines cocaine opioids ecstasy
Sleeping environment: bed is comfortable room is quiet room is a good temperature
Further explain any of the above if needed:

Sleepiness Scale

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 some of these things recently try to work out how they would have affected you. Use the following scale to choose the *most appropriate 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 (example: a theater or meeting):	
As a passenger in a car for an hour without a break:	
Lying down to rest in the afternoon when circumstances permit:	
Sitting and talking to someone:	
Sitting quietly after a lunch without alcohol:	
In a car (you are driving), while stopped for a few minutes in traffic:	

Other Comments
Please provide any other information that may be helpful to the provider caring for you:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: ____ Date of Birth: _____________
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider (Please insert name of provider) ___________________________________ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information ____________**Colorado Sleep Institute**_________________.
Address of the recipient or where my health information should be delivered:
______**4895 Riverbend Road Boulder, CO 80301 Fax: (720)540-4250**____________.

Purpose: I understand that the specific purpose of this Authorization is **At the request of the patient** .
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ All of my health information described above except for the following: ____.
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)____.

\

Term: This Authorization will remain in effect:

- ❑ From the date of this Authorization until the_____day of_______, 20 .
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:

Expiration or Revocation of Authorization: I understand that I may revoke (at any time) this Authorization for any reason and that such revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

_________________________ _________________ _________________
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

______________ ________________ _________ _____________
Guardian/Representative Legal Relationship Date Witness

1 NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act

Comprehensive Care for Sleep Disorders

Permission to Communicate Protected Health Information

I,_________________________________DOB:______________________, grant permission for Colorado Sleep Institute to disclose my health information as specified below:

I authorize my detailed health information to be disclosed:

_____On my home voicemail ____(phone #)

_____On my work voicemail ____(phone #)

_____On my mobile voicemail ____(phone #)

_____Via Encrypted Text Message ____(phone #)

_____Via Encrypted Email ____(email)

_____Do not leave any detailed information on voicemail, text, or email, attempt to contact directly.

Additionally, I authorize detailed health information to be disclosed to the following person(s):

Name	DOB	Relationship	Phone

***I understand that this may include detailed personal medical information including, but not limited to: medical services to be provided, notification that items such as refills are ready for pick-up, billing information, or test results.**

____ Date:_____________________
Signature of Patient or Authorized Representative

This consent form will expire when revoked in writing by the patient/representative or, in the case of a minor, on the date the minor becomes an adult under state law.

No-Show and Late-Arrival Policy

In an effort to maximize the time our sleep specialists spend with you and to minimize wait times, we are notifying you of our *No-Show and Late-Arrival Policies*.

No-Show Policy

The Colorado Sleep Institute requires:

- That all appointments be cancelled or rescheduled with at least a **48-hour notice** in order to give us time to fill the appointment with another patient.
- Failure to cancel or reschedule your appointment with at least a 48-hour notice will result in a **$50.00 charge**.
- Failure to show up for your appointment without notification will also result in a $50.00 charge

Late arrival policy

The Colorado Sleep Institute requires:

- That you show up 15 minutes prior to your scheduled appointment time (30 minutes before a new patient appointment if you have not yet filled out your questionnaire).
- That you complete the new patient questionnaires (new patients only) prior to your appointment. Failure to complete the packet prior to your appointment will result in the rescheduling of the appointment.
- That if you arrive more than 10 minutes late for a scheduled appointment then your appointment will be rescheduled for another day.

Notifications

The Colorado Sleep Institute proactively notifies all our patients in the following ways in order to educate them of our No-Show and Late Arrival Policies:

- Written letter included in new patient packet
- Automated appointment reminder, which also gives you the option to reschedule, cancel, or confirm appointment
- Email (if applicable)
- Company Financial Policy
- Notification sign at the front desk