SleepRite

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Patient Registration & Insurance Form

Patient Information	
Name:	Address:
Date of Birth:	City:
Gender: ☐ Male ☐ Female	State: Zip:
Social Security #:	Home telephone:
☐Single ☐ Married ☐Other	☐Employed ☐Full-Time Student ☐Part-Time Student
Height: Weight:	Employer or School Name:
Neck Circumference:	
Currently using supplemental oxygen: Yes/No	Currently using CPAP: Yes/No

Insurance Information	
Insured Name:	Insurance Company:
Insurance ID #:	Group Number:
Relation to Patient:	Insured DOB: Gender: ☐ Male ☐ Female
Insured Address(if different than patient):	

Physician Information	
Physician Name:	Address:
Practice Name:	City:
Phone: Fax:	State: Zip:

Reason for Sleep Study: Please check all that apply:

☐Excessive Daytime Sleepiness	☐Witnessed Apnea	☐ + Nocturnal O2 Desat	☐Snoring
☐AM Headaches	☐Hypertension	☐Mood Disorder	☐Insomnia
☐Ischemic Heart Disease	☐History of Stroke	*Epworth Sleepiness Score __________	

Given a history and physical findings suggesting a sleep disorder, I am referring this patient for evaluation using a type 3 sleep diagnostic system. This test and interpretation is medically necessary to obtain information which will assist in the diagnosis and treatment of this patient.

Physician Signature:	Date: