2700 Bellflower Blvd. Ste 315 ☼ Long Beach, CA 90815
p 562.420.7353 ☼ f 562.420.7350 ☼ thesleepapneagirl@gmail.com

SLEEP DISORDER SYMPTOMS ASSESSMENT

First Name:_____ **Last Name:**_____ **Date of birth:**_____

Sex: Male ☐ **Female** ☐ **other:** ☐

Height: _____ **Weight:** _____ **BMI:** _____ **Neck Size:** _____

Please check all medical conditions that apply:

	high blood pressure		Heart Disease		Stroke		Insomnia
	Frequent urination at night (Nocturia)		Diabetes		Depression		Obesity

Assessment of Sleep Disordered Breathing
Please circle **yes, no or don't know** for each question.

1. Do you snore often (3 or more nights a week)? **YES** **NO** **DON'T KNOW**
2. Is your snoring loud enough to be heard through a Closed door or annoying to other people? **YES** **NO** **DON'T KNOW**
3. Have you noticed, or be told, that during sleep you Frequently stop breathing or gasp for air? **YES** **NO** **DON'T KNOW**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation.

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 OFF
Sitting and reading?	
While watching television?	
Sitting inactive, in a public place (E.G theater or a meeting)	
As a passenger in a car for an hour without a break?	
Lying down to rest in the afternoon?	
Sitting and talking with someone?	
Sitting quietly after lunch w/o alcohol?	
In a car, while stopped for a few minutes in traffic?	
TOTAL	

ARE YOU CURRENTLY USING A CPAP? YES NO IF YES, HOW LONG _____

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PATIENT INFORMATION:

First Name: _____ Last name: _____ Date of Birth: _____

Sex: _____ Age: _____ Social Security #: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: ( ) _____ Cell phone: ( ) _____

Email: _____

Circle one: Single Married Divorced Separated Widowed

Employer: (if applicable) _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone: ( ) _____

SPOUSE INFORMATION:

First Name: _____ Last name: _____ Date of Birth: _____

Sex: _____ Age: _____ Social Security #: _____

Home address: _____ City: _____ State:_____ Zip:_____

Home phone: ( ) _____ Cell phone: ( ) _____

Employer: (if applicable) _____

Employer's Address: _____ City: _____ State:_____ Zip:_____

Work Phone: ( ) _____

Insurance Information

Primary Coverage

Name of company: _____ Name of Primary Subscriber: _____

Subscriber Social security #: _____ Insurance ID #: _____

Group #: _____

Secondary Coverage

Name of company: _____ Name of Primary Subscriber: _____

Subscriber Social security #: _____ Insurance ID #: _____

Group #: _____

WE BILL YOUR SERVICES TO YOUR INSURANCE COMPANY AUTOMATICALLY.
PLEASE PROVIDE CURRENT AND CORRECT ADDRESS AND INFORMATION TO EXPEDITE THIS PROCESS.

THE Sleep Apnea GIRL INC.
HEALTHY ZZZ'S ARE GOOD!

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CURRENT MEDICATION

Medication	Dosage	Taken for how long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the counter medications _____

_____

SYSTEMS REVIEW

Have you seen an Ear, Nose, and Throat Specialist?	YES _____	NO _____
Have you had sinus x-rays?	YES _____	NO _____
Do you have frequent nose bleeds?	YES _____	NO _____
Do you have nasal allergies?	YES _____	NO _____
Does your nose become plugged up during the year?	YES _____	NO _____
Do you have difficulty breathing through your nose at any time?	YES _____	NO _____
Do you have problems with persistent cough?	YES _____	NO _____
Do you have problems with shortness of breath?	YES _____	NO _____
Do you have problems with coughing at night?	YES _____	NO _____
Do you have problems with wheezing?	YES _____	NO _____
Do you have persistent hoarseness or difficulty swallowing?	YES _____	NO _____
Do you have severe heart fluttering tightness in your chest or chest pain?	YES _____	NO _____
Have you had stomach burning, or other signs of ulcers?	YES _____	NO _____
Do you take antacids?	YES _____	NO _____
Have you had problems with frequent urination or other urinary problems?	YES _____	NO _____

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2016 Insurance Changes and Law Disclaimer

Dear valued patient,

We are a PPO and cash provider only. There are many new insurance changes that we cannot verify due to the volume of phone calls. We will bill insurance as a courtesy to our patients and it is the responsibility of the patient to be aware of any policy changes. You will be responsible for your Deductible, Copayment, and Coinsurance if applicable. Please speak to billing office or Office Manager with any questions or concerns.

Insurance Disclaimer:

"A quote of benefits and/or authorization does not always guarantee payment of verified eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary under your agreed health plan." Every effort will be made by this office to have all services and procedures covered by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered benefit under your plan the patient then becomes responsible for the amount due.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.

Sincerely,

Annette Barnett Sleep Educator

Print Name _____

Signature _____

Date _____