Santa Monica
SleepDisordersCenter
at St. John's Medical Plaza
Daniel Norman, M.D., Medical Director
Diplomate, American Board of Sleep Medicine

1301 Twentieth St., Suite 370
Santa Monica, CA 90404

Tel: (310) 828-2293
Fax: (310) 453-3759

PATIENT REGISTRATION FORM

NAME OF PATIENT:_____ _____ _____
LAST FIRST MI

DATE OF BIRTH: _____ AGE:_____ SS #: _____ GENDER : M / F MARITAL STATUS: _____

RACE:_____ ETHNICITY:_____ CELL# _____ PREFERRED LANGUAGE:_____

E-MAIL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME TEL.#: _____ DAYTIME TEL. #: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

REFERRING PHYSICIAN: _____ PHONE: _____

PRIMARY CARE PHYSICIAN:_____ PHONE: _____

ARE YOU INSURED THROUGH: ☐ PPO ☐ MEDICARE ☐ MEDICARE/MEDI-CAL ☐ MEDICARE/SUPPLEMENT
☐ SELF PAY ☐ OTHER:_____

PRIMARY INSURANCE: _____

NAME OF INSURED: ☐ SELF OTHER:_____ DOB :_____ SS#_____

ID#: _____ GRP#: _____ POLICY # : _____

SECONDARY INSURANCE: _____

NAME OF INSURED: ☐ SELF OTHER:_____ DOB :_____ SS#_____

ID#: _____ GRP#: _____ POLICY # : _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT _____

HOME TEL.#: _____ WORK TEL.#: _____ CELL#: _____

I hereby authorize payment of my medical and surgical insurance benefits to Santa Monica Sleep Disorders Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Santa Monica Sleep Disorders Center. I authorize Santa Monica Sleep Disorders Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

PATIENT'S SIGNATURE: _____ **DATE:** _____

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Preferred Method for Receiving Confidential Communication & Authorization for Disclosure of Protected Health Information

This office will generally contact patients in accordance with your preferences listed below:

Home Telephone (___) _____

[ ] Okay to leave message with detailed information.
[ ] Leave message with call back number only.

Cellular Telephone (___) _____

[ ] Okay to leave message with detailed information.
[ ] Leave message with call back number only.

Work Telephone (___) _____

[ ] Okay to leave message with detailed information.
[ ] Leave message with call back number only.

Written Communication

[ ] Okay to mail to my home address
[ ] Please mail to another address: _____

Electronic Communication

[ ] Okay to email me to the following email address _____
[ ] Okay to receive electronic financial statements
[ ] I prefer to use the Patient Portal. (You will need to create an account to access our Patient Portal, and will receive an email notifying you of new documents available for viewing on the Patient Portal).

I hereby authorize the office of Santa Monica Sleep Disorders Center to contact the following person(s) with regard to my medical information:

_____ _____
First & Last Name / Relationship Telephone Number

In addition to my referring doctor, I hereby authorize the office of Santa Monica Sleep Disorders Center to send sleep study reports and office notes to the following **doctor(s):**

_____ _____/_____
Doctor's First & Last Name / Specialty Telephone Number / Fax Number (if available)

_____ _____/_____
Doctor's First & Last Name / Specialty Telephone Number / Fax Number (if available)

I wish to place the following restrictions on the disclosure of my health information:

_____

In general the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information (PHI). The privacy rule required healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. The complete Notice of Privacy Practices for the office is available for viewing at our reception area and online at our website www.santamonicasleep.com.

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____ _____
PATIENT NAME SIGNATURE DATE

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24 HOUR CANCELLATION, "NO-SHOW" FEE POLICY, FEES FOR FORM COMPLETION, NON-COVERED & ADMINISTRATIVE SERVICES

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Santa Monica Sleep Disorders Center reserves the right to charge a **fee of $50.00** for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Insurance Health Plans do not pay for all your health care needs. They pay for covered items and services when their rules are met. We have found the need to inform you that the services below are not covered.

Completion of a pre-printed form requiring	
○ A check mark only	no charge
○ Another document or detailed explanation	$25.00
Copy of part or all of patient chart	
○ Less than 10 pages	no charge
○ 10 - 50 pages	$ 15.00
○ Additional pages (each)	$0.25
Dictated letters or Reports not directly related to your office visit (i.e. letter to employer, landlord, etc.)	$100.00
Special Forms	
Disability Forms	
▪ Initial	$30.00
▪ Supplemental reports	$10.00
Prescription Authorization Forms	$20.00
Disability Parking Placard Forms	$20.00
Medical Baseline Allowance Application	$30.00
Air On Board	$30.00
FAA certification (for Pilots)	$100.00
Jury Duty Summons	$30.00

NOTE: Patients must pay the fee before these forms will be processed.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____	_____	_____
PATIENT NAME	SIGNATURE	DATE

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SLEEP HISTORY QUESTIONNAIRE

Date:_____

Name: _____ DOB _____ Age:____ Ht:___ ft___in , Wt:____lbs, Collar/Neck Size:_____in

My main sleep complaint is:_____

How severe is your problem? _____

Rate the severity of the problem: Mild > 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 < Severe

How long have you had this problem?_____

When does this problem occur?_____

Can you attribute the cause of this problem to anything? _____

_____

Are there other symptoms associated with the problem? _____

_____

What makes this problem worse or better? _____

_____

Your Past Medical History

Diabetes……..	No	Yes
Hypertension……..	No	Yes
Congestive Heart Failure…	No	Yes
Cancer (type_____)…	No	Yes
Stroke / TIA ……..	No	Yes
Arthritis/gout……..	No	Yes
Heart attack or stent…….	No	Yes
Depression …….	No	Yes
High cholesterol…..……..	No	Yes
Seizures or epilepsy……	No	Yes
Atrial Fibrillation…….	No	Yes

Other: _____
_____
_____
_____

Usual Sleep Habits:

___snoring
___can't fall sleep at night
___can't stay asleep at night
___excessive sleepiness
___restless sleep
___other :_____

Bedtime: _____pm/am
How long does it take you to fall asleep? _____
Time you get out of bed:_____ am/pm
Awakened by(please circle): alarm/other person/self
Do you sleep in on weekends/off days?_____
Frequent travel across time zones?_____
# of naps per week____ Duration of naps_____

What position do you sleep in:

	Never	Sometimes	Usually
Back			
Side			
Front			

Patient Social History

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Living with: ❑Alone ❑Spouse ❑Significant other ❑Roommate ❑Other

Use of alcohol: ❑Never ❑Rarely ❑Former ❑Current: _____glasses/day

Use of tobacco: ❑Never ❑Previously / quit ❑Currently smoking

How many years have you /did you smoke ____ # Packs/day ___

Use of Drugs: ❑Never ❑Type/Frequency_____

How much caffeine coffee, tea, or soda do you drink each day? ____cups am, ___ pm

Excessive exposure to: ❑ Chemicals ❑ Dust ❑ Solvents ❑Smoke ❑Pet Hair

What medications are you taking?

	Medication	Dose	Reason is taken
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

List previous hospitalizations/Surgeries/Serious Injuries **Date?**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: ❑None or Please list:

Medication allergies:_____

Food allergies: _____

Family Medical History – (please include snoring, sleep issues, high blood pressure, diabetes, cardiovascular, and neurologic or psychiatric diseases)

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

PATIENT'S NAME:_____ **D.O.B.** :_____

CONSTITUTIONAL

Good general health lately……..	No	Yes
Recent weight change…….	No	Yes
Fatigue……	No	Yes
Headaches……...	No	Yes
Fevers.....	No	Yes
Night sweats.....	No	Yes

EYES

Wear glasses/contact lenses……..	No	Yes
Glaucoma or Cataracts……	No	Yes
Eye dryness/itchiness……...	No	Yes

ENT

Ringing in the ears…….	No	Yes
Earaches or drainage……..	No	Yes
Sinus problems……...	No	Yes
Nose bleeds……	No	Yes
Dry mouth or nose……	No	Yes
Teeth clenching/grinding……	No	Yes
Bad breath or bad taste……...	No	Yes
Sore throat .....……	No	Yes
Jaw clicking or locking……	No	Yes

CARDIOVASCULAR

Heart trouble……	No	Yes
Palpitations……...	No	Yes
Chest pains……..	No	Yes
Sudden heartbeat changes……..	No	Yes
Swelling of feet, ankles or hands……	No	Yes

RESPIRATORY

Frequent coughing……...	No	Yes
Spitting up blood…….	No	Yes
Shortness of breath……..	No	Yes
Asthma or wheezing……	No	Yes

GASTROINTESTINAL

Loss of appetite……	No	Yes
Nausea or vomiting…….	No	Yes
Frequent diarrhea…….	No	Yes
Constipation…….....	No	Yes
Blood in stool……..	No	Yes
Stomach pain……	No	Yes
Reflux / Heartburn……	No	Yes
Abdominal bloating……	No	Yes

GENITOURINARY

Frequent urination……	No	Yes
Getting up more than once a night to urinate…..	No	Yes
Erectile Dysfunction ……..……	No	Yes
Incontinence or dribbling…….	No	Yes

MUSCULOSKELETAL

Joint pain…….……	No	Yes
Muscle pain or cramps……	No	Yes
Back/Neck pain…….	No	Yes
Difficulty in walking……	No	Yes

NEUROLOGICAL

Frequent or recurring headaches……...	No	Yes
Head injury……	.No	Yes
Light headed or dizzy……...	No	Yes
Convulsions or seizures……	No	Yes
Numbness or tingling sensations……..	No	Yes
Tremors……	No	Yes
Falls……	No	Yes

PSYCHIATRIC

Memory loss or confusion……	No	Yes
Focus difficulties……	.No	Yes
Anxiety……	No	Yes
Depression……	No	Yes
Stress ……	No	Yes

ENDOCRINE

Thyroid disease……..	No	Yes
Excessive thirst or urination……..	No	Yes
Heat or cold intolerance……..	No	Yes
Low testosterone……..	No	Yes
Irregular menstruation……..	No	Yes
Menopausal……..	No	Yes

SKIN

Rash or itching…….	No	Yes
Skin irritation……..	No	Yes

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts…….	No	Yes
Easily bruise or bleed……..	No	Yes
Anemia……	No	Yes
Iron Deficiency……	No	Yes
Lower extremities edema……	No	Yes

SLEEP-RELATED CONDITIONS

Very loud snoring. .....……	No	Yes
Stop breathing during sleep…….....	No	Yes
Awaken with choking sensations……	No	Yes
Awakened with heart racing/palpitations…….	No	Yes
Unable to sleep in a flat position……	No	Yes
Get up to urinate more than once each night… …… ..	No	Yes
Awaken with headaches……	No	Yes
Unrefreshed after napping…….……	No	Yes
Grind teeth in sleep……	No	Yes
Jaws ache in the morning……	No	Yes
Paralysis or inability to move on awakening…..	No	Yes
Sudden weakness in knees, legs, or elsewhere in body when excited, happy, or upset……	No	Yes
Falling asleep at inappropriate times…….. .	No	Yes
Driven miles past destination w/little awareness…….	No	Yes
Near-accidents due to sleepiness……..…	No	Yes
Driving accidents due to sleepiness…….	No	Yes
Restlessness, tingling, or crawling feeling in legs that make it hard to fall asleep……	No	Yes
Experience inability to keep legs still……	No	Yes
Kicking or twitching during sleep……...	No	Yes
Cough up sputum or mucus at night……	No	Yes
Bitter or sour mouth taste in the morning……	No	Yes
Awaken with heartburn…….	No	Yes
Sudden awakening with intense anxiety or dread…	No	Yes
Sleep-walking as an adult……. ..	No	Yes
Sleep-talking as an adult……,……	No	Yes
Bedwetting in adulthood……..	No	Yes
Banging, twisting, or shaking head in sleep……No		Yes
Nocturnal seizures……	No	Yes
Bitten tongue during sleep…….	No	Yes
Use sleeping pills……No		Yes
Bed partner disturbs sleep……No		Yes
Restless sleeper…… ……	No	Yes
Awaken long before it is necessary……No		Yes
Sleep better in unfamiliar setting……No		Yes
Sleep with ear plugs or eye shades……..No		Yes
Awaken with pain……	No	Yes
Light sleeper……No		Yes
Trouble returning to sleep……..	No	Yes
Difficulty falling asleep……No		Yes
Don't feel tired at bedtime…….	No	Yes
Difficulty waking in the morning…….	No	Yes
Function best in the evening……No		Yes
Shift-worker or night work……...No		Yes
Late sleeper…….……..No		Yes

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PATIENT'S NAME:_____ **D.O.B.** :_____

Epworth Sleepiness Scale

Date: _____

Please read these instructions carefully:

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you haven't 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
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (i.e., a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
Total	_____

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PATIENT'S NAME:_____ **D.O.B**. :_____

SPOUSE OR ROOMMATE QUESTIONNAIRE

Date: _____

Please check off any of the following behaviors you have noticed occurring during the patient's sleep:

____ loud snoring
____ twitching of legs or feet while asleep
____ gasping
____ grinding teeth
____ sleepwalking
____ sitting up in bed but not awake
____ kicking with legs during sleep
____ acting out dreams
____ becoming very rigid and/or shaking
____ light snoring
____ pauses in breathing
____ snorts
____ sleep talking
____ bed wetting
____ head rocking or banging
____ getting out of bed but not awake
____ biting tongue

How long have you been aware of these behaviors: _____

Describe the behaviors checked above in more detail. Include a description of the activity: the time of night when it occurs, its frequency during the night and whether it occurs every night.

_____

_____

_____

_____

_____

_____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____D.O.B.:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns _____ + _____ + _____

TOTAL: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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STOP –BANG QUESTIONNAIRE

PATIENT NAME: _____ DOB:___/___ /_____ DATE:___/___ /_____

Snoring: Do you snore loudly? (louder than talking or loud enough to be heard through a closed door)
□ Yes □ No

Tiredness/fatigue: Do you feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep?
□ Yes □ No

Observed apnea: Has anyone ever observed you stop breathing during your sleep?
□ Yes □ No

Pressure: Do you have or are you being treated for high blood pressure?
□ Yes □ No

Body mass index: is your BMI greater than 35? (see table for guide)
□ Yes □ No

Age: Are you older than fifty years of age?
□ Yes □ No

Neck Size (measured around Adam's apple):
For men: Does your neck measure more than 17 inches around?
For women: Does your neck measure more than 16 inches around?
□ Yes □ No

Gender: Are you male?
□ Yes □ No

BMI Guide
(BMI is >35 if weight in lbs. is greater than what is listed for the corresponding height below)

Height	Weight	Height	Weight
4'10"	167	5'8"	230
4'11"	173	5'9"	237
5'0"	179	5'10"	243
5'1"	185	5'11"	250
5'2"	191	6'0"	258
5'3"	197	6'1"	265
5'4"	204	6'2"	272
5'5"	210	6'3"	279
5'6"	216	6'4"	287
5'7"	223	6'5"	295

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