Patient Demographics

Today's Date:_______________

Patient Name:_______________________________ Date of Birth:________________ Age:________________

SS#_________________________________ Male____ Female____ Marital Status: Married__ Single__ Other__

Primary Address:____

Mailing Address Or N/A: ____

Home Phone #_____________________________ Work #____

Cell Phone # ______________________________ Email Address: _______________________________________

Patient Employer: ____________________________ Occupation :_______________________________________

Spouse's Name:_____________________________________ Spouse DOB:_______________________________

Spouse's Employer:_________________________________ Spouse's Work # _____________________________

Chief Complaint:____

Referring Physician/Clinic:_______________________________ Preferred Language:________________

Physician Phone # _______________________________ Physician Fax #__________________________________

Emergency Contact:__________________________ Phone: ___________________ Relation:________________

Primary Insurance Information

Insurance Company:_______________________________Address:_______________________________________

Phone # _______________________ Fax # ___________________ Policy Holder:___________________________

Policy Holder's Date of Birth: _______________ID # ____________________Group/ Policy #________________

Secondary Insurance Information

Insurance Company:_______________________________Address:_______________________________________

Phone # _______________________ Fax # ___________________ Policy Holder:___________________________

Policy Holder's Date of Birth: _______________ID # ____________________Group/ Policy #________________

Please Indicate the Following

Best Contact: Home__ Work__ Alt.__ Email__ Other____________ **May we leave a message**: Yes__ No__

Copy of HIPAA: Accept__ Decline__ **Copy of Patient Rights & Responsibilities:** Accept___ Decline___

ALLERGIES:

EPWORTH 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 (e.g. 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 lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________

TOTAL ________

THANK YOU FOR COMPLETING THIS QUESTIONAIRE
ALL QUESTIONAIRES ARE KEPT
CONFIDENTIAL TO PROTECT OUR PATIENTS RIGHTS
Thank you for your cooperation