ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

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Anchorage, AK 99508
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Fairbanks
1901 Airport Way, Ste. 101
Fairbanks, AK 99701
P: 907.374.3063
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Soldotna
588 Pace Street
Soldotna, AK 99669
P: 907.420.0540
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Wasilla
1051 East Bogard Rd., Ste. 1
Wasilla, AK 99654
P: 907.357.6700
F: 907.357.6672

Self Referral / New Patient Intake Form

Patient Information:

Patient Last Name:______________________________First Name:_____________________________DOB:__________________________

Address:_______________________________________City:_____________________________State/Zip:_____________________________

Home Phone: __________________________________Cell Phone: ____________________ Work Phone:__________________________

Email address: ____Occupation: ______________________________

Primary Insurance Information:

Insurance Carrier:______________________________ID Number:_____________________Group Number:________________________

Claims Mailing Address:_________________________________City:__________________________State/Zip:______________________

Relationship to Insured: Self Spouse Other:____

Secondary Insurance Information:

Insurance Carrier:______________________________ID Number:_____________________Group Number:________________________

Claims Mailing Address:_________________________________City:__________________________State/Zip:______________________

Relationship to Insured: Self Spouse Other:____

Sleep Questionnaire:

Do you snore or have you been told that you snore?	Yes	No
Do you stop or have you been told that you stop breathing in your sleep?	Yes	No
Do you have daytime sleepiness?	Yes	No
Do you feel rested in the morning?	Yes	No
Do you have difficulty focusing or concentrating during the day?	Yes	No
Does leg restlessness keep you awake at night?	Yes	No
Do you have insomnia?	Yes	No
Do you have asthma, emphysema or other breathing issues?	Yes	No
Do you have high blood pressure?	Yes	No
Have you ever had a stroke or "Warning stroke"?	Yes	No
Are you on oxygen?	Yes	No

What is your height? ___________________________________ What is your weight? ___________________________________

What is you main reason to see the sleep doctor? ____

Is there anything you would like the sleep doctor to know? ____

How did you hear about the Alaska Sleep Clinic? ____