



## 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 your 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? \_\_\_\_\_