SLEEP AND BEHAVIOR MEDICINE INSTITUTE

PATIENT DEMOGRAPHIC & BILLING FORM

Patient Information

Last Name: _____First:_____ MI: _____
Nick Name: _____ Age: _____ Date of Birth: ___/___/_____
Sex: F M Marital Status: Single, Married, Divorced, Widowed, Legally Separated.
Social Security Number: _____E-mail: _____
Street Address: _____Apt. No: _____
City: _____State: _____Zip: _____-_____
Home phone: _____Cell phone: _____ Work phone: _____
Spouse Name _____Phone Number: _____
Emergency Contact Name: _____Phone Number: _____

Patient's Referral Information

Primary Care Physician: _____Phone: _____
Address: _____ Fax: _____
Referring Physician: _____Phone: _____
Address: _____Fax: _____

Patient's Insurance Information

Primary Insurance Company's Name: _____
Name of Policy Holder: _____Date of Birth: __/__/_____
Insurance ID Number: _____Group Number: _____
Secondary Insurance Company's Name: _____
Name of Policy Holder: _____Date of Birth: __/__/_____
Insurance ID Number: _____Group Number: _____

Guarantor/Parent Information

Responsible Party Last Name: _____First:_____ Middle_____
Relationship to Patient: _____Responsible Party Date of Birth: __/__/____
Guarantor's Social Security Number: _____
Guarantor's Address: _____Apt. No: _____
City: _____State: _____Zip Code: _____
Home phone: _____Cell number: _____
Parents Names: _____Phone # (if different from above): _____
_____

Credit Card/ Billing Information

Please be advised, the credit card below will not be charged without prior acknowledgement of the patient, except for missed appointments and co-pays

Type: Master Card Visa American Express Discover Card
Credit Card Number: _____
Expiration Date: _____ CVC: _____

Patient Questionnaire

Chief Complaints (please, list and describe the reason of your appointment, your problems or concerns)

_____
_____
_____
_____

Medical History: **Weight: _____Height:_____**

Do you have special needs or use medical devices: No Yes _____

Have you ever had an MRI/CT Scan? Year_____ Have you ever had a Sleep Study? Year_____

Allergies:

Are you allergic to any medicine, tape, iodine or latex? No Yes _____

Environmental Allergies: _____

Food or Animals: _____

Have you been diagnosed or are currently having problems with any of the following:

- Headache No Yes _____ Eye problem No Yes _____
- Mouth Breathing No Yes _____ Dentures No Yes _____
- Teeth problems No Yes _____ Skin problems No Yes _____
- Ears (hearing loss ear infection, tonsils, adenoids) No Yes _____
- High blood pressure, arrhythmias, stents, heart surgery, pacemaker and heart attack) No Yes_____
- Asthma,COPD,Apnea,Pneumonias No Yes __ Seizures, Stroke, Parkinson MS No Yes _____
- Diabetes,obesity,thyroid,metabolic problems No Yes _____ Blood Disorder No Yes _____
- Head injury, brain trauma, loss of consciousness No Yes _____
- Genital/Urinary problems (prostate,cystitis) No Yes _____
- Intestinal problems (gastritis,IBS) No Yes _____
- Arthritis No Yes _____ Pain No Yes _____
- Cancer No Yes _____
- Depression No Yes _____ Anger problems No Yes_____
- Bipolar Disorder No Yes _____ Schizophrenia No Yes _____
- Asperger's No Yes _____ Anxiety No Yes _____
- Panic attack No Yes _____ Obsessive Compulsive disorder No Yes _____
- ADHD/ADD No Yes _____ Learning disability No Yes _____
- Chronic Fatigue, Fibromyalgia No Yes _____ Sleep disorder No Yes _____
- Bad habits No Yes _____
- Others: _____

Previous Hospitalization/surgery No Yes

(if yes, year and reason): _____

Past Medications:

Please list past medications tried and side effects: _____

_____

List all your current medications, vitamins, herbs, supplements, etc.

Medication	Dose	Frequency

Pharmacy Information
Pharmacy Name: _____
Phone: _____Fax: _____
Address: _____
City:_____ State: ____Zip: _____

Social History
Do you currently smoke? No Yes (if yes, packs/day) _____#years_____
Do you drink Alcohol? No Yes (if yes, amount /week)_____
Do you drink coffee? (if yes, list amount)_____cola_____ tea_____
Do you use recreational drugs? No Yes_____
Dou you use pain killers? No Yes _____
What is your occupation? _____ shift worker? No Yes _____
Who do you live with? _____

Family History

	Please Circle	Age(s)	Health Problems?	Suicide?	Have been in Military?
Father	Living Deceased				
Mother	Living Deceased				
Sibling	Living Deceased				
Sibling	Living Deceased				
Sibling	Living Deceased				
Child	Living Deceased				
Child	Living Deceased				

Developmental History (for children, or if you know about yourself)
This child is from pregnancy number _____
Problems with mother during pregnancy (eclampsia,diabetes,high blood pressure)No Yes___
Problems during delivery (prematurity,forceps,hypoxia) No Yes _____
Breast feeding? No Yes _____How Long? _____
Sleep problems in infancy? No Yes _____
Medical/Behavioral problems during childhood
(earinfections,seizure,ADHD,anxiety,bedwetting,etc.)_____

Patient/Guardian Signature: _____Date: _____