eos sleep NY

NEW PATIENT REGISTRATION FORM

Date _____

PATIENT INFORMATION

Whom may we thank for referring you? _____

Name (Last, First, MI) _____ Age _____

Gender _____ Date of Birth _____/_____/_____ Marital Status _____

Address _____ Apt# _____

City _____ State _____ Zip _____

SSN: _____/_____/_____ Email _____

Home Phone _____ Work Phone _____ Ext _____

Mobile Phone _____ Other Phone _____

Employer _____

Emergency Contact _____ Phone _____

INSURANCE INFORMATION:

Please note that if your carrier requires Pre Authorization or Pre Approval you are required to obtain prior to your appointment. You may need to check with your carrier if you have a waiting period.

Primary Ins _____ Ins Phone _____

Primary Ins Address _____

Subscriber _____ DOB _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins ID# _____ Ins Grp# _____

Secondary Ins _____ Ins Phone _____

Secondary Ins Address _____

Subscriber _____ DOB _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Ins ID# _____ Ins Grp# _____

OTHER MEDICAL CONTACTS

Primary Care/Physician _____ Phone _____

Address _____

Pharmacy _____ Phone _____

Address _____

DISCLOSURE OF BENEFITS

I have received a copy of the HIPAA Privacy Notice and authorize release of information concerning my health care, advice and treatment provided for the purpose of evaluating and / or administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the physician.

_____ Date _____

Signature of Patient or Patient Representative

eos sleep NY

MEDICAL HEALTH HISTORY

Patient Name _____ Today's Date _____

Patient Date of Birth _____ Age _____ Gender ☐ Male ☐ Female

Occupation _____ Height _____ Weight _____

Reason for Consultation

- ☐ Ear Infection
- ☐ Ear Aches
- ☐ Ear Discharge
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Earwax Build-Up
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Sinus Problems
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Nose Fracture
- ☐ Foreign Body in Ear/Nose
- ☐ Sore Throat
- ☐ Swallowing Difficulty
- ☐ Mouth/Tongue Sores
- ☐ Thyroid Nodule
- ☐ Neck Mass
- ☐ Headache
- ☐ Vertigo/Dizziness
- ☐ Allergies
- ☐ Cough
- ☐ Hoarseness
- ☐ Post Nasal Drip
- ☐ Tonsil Problems
- ☐ Other _____

MEDICATIONS List ALL medications you are currently taking including herbs, supplements & over the counter medications.	

MEDICAL HISTORY					
☐	Hypertension	☐	Sleep Apnea	☐	Bleeding Disorder
☐	Heart Disease	☐	Thyroid Disease	☐	Diabetes
☐	Kidney Disease	☐	Pregnant	☐	Other
☐	Liver Disease	☐	Cancer	☐	Other

MEDICATION ALLERGIES	**Reaction**

PAST SURGICAL HISTORY	**Date**

SOCIAL HISTORY	**CIGARETTES**	# per day	# of years	☐ Discontinued
	ALCOHOL	# per week		

Other health concerns: _____

_____

_____

_____

Physician Signature: Date

eos sleep NY

Snoring and Sleep Apnea Questionaire

Name _____ Date _____

Height _____ Weight _____ Neck Circumference _____

Clinical Information (Check all that apply)

☐	Disruptive snoring	☐	Witnessed apnea during sleep
☐	Disturbed or restless sleep	☐	Frequent unexpected arousals from sleep
☐	Non-restorative sleep	☐	Regular sedative / sleep-aid use
☐	Regular alcohol use	☐	Choking / gasping during sleep
☐	Excessive daytime sleepiness	☐	Excessive daytime fatigue

Thornton Snoring Scale

What is your Snore Score? Snoring can be a harmless annoyance or an indication of a more serious sleep disorder. This short quiz can help determine if you may need further evaluation for a sleep condition. *A score of 5 or higher is associated with sleep-disordered breathing.*

Use the following scale to choose the most appropriate number that describes the snoring in your situation:

0 = **Never**
1 = **Infrequently** (1 night per week)
2 = **Frequently** (2-3 nights per week)
3 = **Most of the time** (4 or more nights per week)

Snoring affects my relationship with my partner	
Snoring causes my partner to be irritable or tired	
Snoring requires us to sleep in separate rooms	
The snoring is loud	
Snoring affects other people when I sleep away from home (e.g. hotel)	
TOTAL	

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? Please refer to your recent usual way of life.
Normal 0-10, Borderline 10-12, Abnormal 12-24

Even if you haven't done some of these things recently, please try to work out how they would have affected you if they occurred. 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 theatre 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 a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total	

Physician Signature: _____ Date _____