

Confidential

REGISTRATION INFORMATION

Patient Name _____ Date of Birth _____

Last First Middle Initial Age _____ Sex M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell phone _____ Work Phone _____ Ext _____

Best time and place to reach you _____ Email _____

Marital Status Married Widowed Single Separated Divorced

Occupation _____ Present Employer _____

Address _____ City _____ State _____ Zip _____

Contact in Emergency/Next of Kin

Name _____ Relationship _____

Last First Middle Initial

Home Phone _____ Cell phone _____ Work Phone _____ Ext _____

Social Security _____

Primary Insurance Information

Insurance Company _____

Insurance Company Address _____

Identification # _____ Group & Policy # _____

Secondary Insurance Information None

Insurance Company _____

Insurance Company Address _____

Identification # _____ Group & Policy # _____

Physician and Pharmacy

Name of Physician or Individual referring you here _____

Primary Medical Physician _____ Should we send Sleep Study report to your PMD Yes No

Preferred Pharmacy _____ Phone _____

Preferred Lab if any Lab corp Qwest Other _____

Are you able to walk unassisted? Yes No Do you use oxygen at night? Yes No Do you use CPAP at night? Yes No

What, if any, you take medications to fall asleep?

Have you received services at Trinitas? Yes No If yes When? _____ MRNo# _____

Date test scheduled _____ Type of Test NPSG CPAP MSLT

Diagnosis _____ Weight >300lbs Yes No Risk of Fall _____

