SOUTH CAROLINA SLEEP MEDICINE
REGISTRATION INFORMATION
PLEASE PRINT

Date:_____

Patient:_____
Last **First** **Middle**

Date of Birth:_____ **Social Security #**_____ **Race**_____

Gender: M__ F__ Marital Status: Single___ Married____ Divorced_____ Widowed____

Mailing Address:_____

City, State, Zip:_____

Preferred Contact Number(s):_____

Patient Employer:_____

Business Address:_____ **Bus. Phone:**_____

Responsible Party (if different from above):_____**D.O.B.**_____

Emergency Contact:_____ **Relationship:**_____ **Contact#**_____

Primary Insurance:_____

Secondary Insurance:_____

Spouse:_____**DOB**_____ **Social Security#**_____

Primary Care Doctor Name:_____

Referring physician:_____

Pharmacy (Location & Phone):_____

MEDICAL HISTORY

Name:_____ **Date:**_____

Please circle all that apply to you:

ADD Anemia Asthma Bipolar Cancer_____ **Depression Diabetes**

COPD Emphysema Fibromyalgia Heart Attack Heart Failure

Hypertension Kidney Failure Reflux Seizure Stroke Sleep Apnea

Hypothyroid Hyperthyroid Other:_____

Surgical History:_____

Smoke: Yes_____**ppd No**___ **Alcoholic beverages: Yes**_____**per day No**_____

Drug Allergies:_____

Please list all current Medications & dosages:_____

EPWORTH SLEEPINESS SCALE

How Sleepy are you?
How likely are you to doze off or fall asleep in the following situations? Please rate your chances of actually dozing not just feeling tired.
SCALE: 0 No chance of dozing 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Sitting & Reading:_____

Watching TV_____

Sitting, inactive in a public place (movie, meeting)_____

As a passenger in a car for an hour_____

Lying down to rest in the afternoon when circumstances permit_____

Sitting and talking with someone_____

Sitting quietly after lunch without alcohol_____

In a car, while stopped for a few minutes in traffic_____

Total_____

HMO AND PPO PATIENTS

It is solely your responsibility to get/or confirm that Authorizations and Referrals have been received and to know the limitations of your insurance benefits.

MOST INSURANCE PLANS DO NOT PAY 100% OF COVERED CHARGES. PATIENTS ARE RESPONSIBLE FOR ALL COPAYMENTS AND DEDUCTIBLES. BECAUSE OF CONTRACT AGREEMENTS AND GOVERNMENT REGULATION, COPAYMENTS AND DEDUCTIBLES WILL NOT BE DISCOUNTED OR "WRITTEN OFF"

UP-TO-DATE PATIENT INFORMATION

SHOULD YOU CHANGE YOUR ADDRESS, TELEPHONE NUMBER, OR INSURANCE COMPANY, PLEASE CONTACT OUR OFFICE SO THAT PATIENT FILES CAN BE UPDATED.

IF YOU HAVE FURTHER QUESTIONS, PLEASE CONTACT OUR OFFICE AND WE WILL BE HAPPY TO ASSIST YOU.

INSURANCE AUTHORIZATION / MEDICAL RECORDS

I authorize South Carolina Sleep Medicine to contact my insurance company for benefits on my behalf for covered services rendered. I request payment be made directly to South Carolina Sleep Medicine for those services rendered. I realize that I am responsible for full payment of charges not covered by my insurance company.

In order to ensure proper follow-up and continuity of care, I authorize South Carolina Sleep Medicine to release medical information to any physician or insurance company involved in my care. I permit a copy of this authorization to be used in place of the original. South Carolina Sleep Medicine reserves the right to charge a Medical Records fee.

I certify that this information is correct and complete. I have also read the Patient Information/Financial Policy of South Carolina Sleep Medicine/ Summerville Sleep Consultants, LLC. I agree to the Privacy Policy which is posted in the lobby at South Carolina Sleep Medicine. (For a hand held copy of South Carolina Sleep Medicines Privacy Policy please ask one of our receptionists). I authorize the use of my signature on all insurance submissions & appeals.

DISCLOSURE

SCSM/Summerville Sleep Consultants, LLC is allowed to disclose/discuss my private information relating to my health or for payment of healthcare services to those listed below.

_____

PATIENT SIGNATURE_____ Date_____