ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

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# 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 you 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? _____