PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth: _____

__Single __ Married __Widowed __Separated __Divorced

Age: _____ Sex: Male_____ Female_____

Social Security Number: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Alternate Phone: _____

Spouse: _____

Emergency Contact: _____

Emergency Phone: _____

EMPLOYMENT INFORMATION

__ Full Time __ Part Time __Retired __Self Employed

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone #: _____

REFFERAL INFORMATION

Referring Physician: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

PRIMARY INSURANCE CARRIER

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber/Member ID: _____

Group #: _____

Effective Date: _____

SECONDARY INSURANCE CARRIER

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber/Member ID: _____

Group #: _____

Effective Date: _____

RESPONSIBLE PARTY

Relationship to Patient: _____

Last Name: _____

First Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

SLEEP CENTER HAWAII

PATIENT SIGN IN SHEET

Patient Name: _____ Date: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Referring Physician: _____ Phone: _____

Other Physician You Would Like Us To Send A Report To:

Name: _____ Phone: _____

Chief Complaint:

_____

Medications:

_____

_____

_____

Allergies:

_____

_____

_____

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

_____

Past Hospitalization History:

_____

_____

Family History:

_____

_____

Family History of Neurological Problems:

_____

_____

Family History of Sleep Problems:

_____

_____

SLEEP CENTER HAWAII

PATIENT SIGN IN SHEET

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS - Do you **now** have any problems related to the following systems? Circle **Y**es or **N**o

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Sweats	Y	N
Weight Loss	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Loss of Vision	Y	N
Pain	Y	N

Other: _____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Weakness	Y	N
Imbalance	Y	N
Headache	Y	N
Forgetfulness	Y	N

Other: _____

Endocrine

Excessive Thirst	Y	N
Too Hot/Too Cold	Y	N
Tired/Sluggish	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Diarrhea	Y	N
Constipation	Y	N

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Irregular Heartbeat	Y	N
Ankle Swelling	Y	N
Poor Circulation	Y	N

Other: _____

Integumentary

Skin Rash	Y	N
Bruise Easily	Y	N
Itching	Y	N
Hives	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other: _____

Ear/Nose/Threat/Mouth

Hearing Loss	Y	N
Ringing in the Ears	Y	N
Vertigo	Y	N
Sinus/Allergy problems	Y	N
Difficulty Swallowing	Y	N
Hoarseness	Y	N

Genitourinary

Urine Retention	Y	N
Urinary Hesitancy	Y	N
Urinary Frequency	Y	N
Loss of Bladder Control	Y	N
Painful Urination	Y	N

Respiratory

Wheezing	Y	N
Persistent Cough	Y	N
Shortness of Breath	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Phlebitis	Y	N
Bleeding	Y	N

Psychological

Depression	Y	N
Insomnia	Y	N
Nervous/Anxious	Y	N

SLEEP CENTER HAWAII

PATIENT SIGN IN SHEET

Patient Name: _____ Date: _____

Social History	YES	NO	Details (amount, how often, occupation)
Alcohol			
Caffeine			
Drugs			
Tobacco			
Married			
Employed			

Tobacco Control Survey

Are you a…

□ Current Smoker □ Former Smoker □ Never Smoker

Race

Please choose one of the following:

□ American Indian or Alaska Native

□ Asian

□ Native Hawaiian or Pacific Islander

□ Black or African American

□ White

□ Hispanic

□ Other Race

Ethnicity

□ Hispanic or Latino

□ Not Hispanic or Latino

□ Prefer not to answer

SLEEP CENTER HAWAII

HIPAA PRIVACY NOTICE

With this consent, the doctor and his/her staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the doctor and his/her staff may call me (number designated below) and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Voicemail Phone Number: _____

With this consent, the doctor and his/her staff may speak and release my PHI to the following spouse, family member, relative, friend or parties listed below.

Name	**Relationship**	**Name**	**Relationship**
_____	_____	_____	_____

With this consent, the doctor and his/her staff may text or email me appointment reminders.

Text appointment reminders: YES / NO **Email appointment reminders**: YES / NO

Designated Cell Phone: _____

Designated Email Address: _____

With this consent, the doctor and his/her staff may mail to my home or other location (designated below) any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

Designated Mailing Address: _____

_____**, Hawaii** _____

This consent covers the period of time from my visit until I revoke my consent in writing. I release the doctor and staff from all legal responsibility that may arise from this authorization. By signing this form, I am consenting to the doctor and his/her staff to use and disclose of my PHI, but only to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I have read the Notice of the Uses and Disclosures of Protected Health Information and may obtain a printed copy of the notice from the receptionist.

Signature of Patient or Legal Guardian Date

Print Name of Patient Print Name of Legal Guardian

Gabriele M. Barthlen, M.D., Ph.D.
Michael R. Slattery, M.D.
98-1238 Kaahumanu Street, Suite 300
Pearl City · Hawaii · 96782
Phone: (808) 456-REST(7378)
Fax: (808) 483-8822

Financial Policy

Thank you for choosing Sleep Center Hawaii, and welcome! We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Depending on your insurance, a copay/co-insurance will be collected at the time of service. For your convenience, we accept cash, check, and all major credit cards.

Your insurance is an agreement between you and your insurance company. As part of our services, we will file your insurance claims for you if you assign benefits to the physicians. If your insurance company does not pay within a reasonable period, you may be responsible for payment. If we later receive a check from your insurer, we will refund any over payment to you.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you read your insurance booklet or copy of the contract your policy falls under, or call your insurance representative to determine your benefits.

In some instances, you may be contacted by your insurance to provide additional information regarding your health, such as preexisting conditions, accidents, treatment, or additional insurance coverage. Please respond to their requests in a timely manner to avoid denial of your claims.

Be prepared to present your insurance card and (two if possible) proof of identity (e.g. driver's license) at each visit. You will be responsible for providing us with a change of address, telephone number and/or insurance information anytime a change occurs.

A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on your contract allowable. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office.

I understand and agree that any unpaid charges shall be paid promptly by me in accordance with terms of this agreement. In the event of default, Sleep Center Hawaii will charge reasonable collection charges, not to exceed 30% of the unpaid balance at the time the account is assigned to a collection agency.

Our Durable Medical Equipment (DME) division that dispenses CPAP/BiPAP machines and accessories may ask to keep a credit card on file before dispensing the equipment.

If you have any questions, please feel free to discuss them with one of our patient billing representatives at (808) 485-1122.

Patient Signature_____ Date_____

Witness _____ Date _____