WESTMORELAND SLEEP MEDICINE
PATIENT REGISTRATION

Patient Name _____ Patient Address _____

PHONE Home _____ Work _____ Cell _____

Birthdate _____ Age _____ Soc. Sec. # _____

Email _____ Referring Doctor _____ Primary Doctor _____

INSURANCE: Primary _____ Secondary _____

Subscriber Name _____ Birthdate _____ Soc. Sec. # _____ Relationship to Patient _____

PRIVACY/HIPAA NOTICE & CONSENT

Westmoreland Sleep Medicine (WSM) has my permission to use and disclose protected health information (PHI) about me for treatment, payment, and health care operations purposes. I have received WSM's Privacy Notice describing their disclosure practices and how I can access my PHI and exercise other rights concerning my PHI. WSM reserves the right to amend their Privacy practices and to have any amendments effective for all PHI, including information created or obtained by WSM prior to the date of the amendment. I am aware I can obtain any revisions or amendments by requesting so in writing. I HAVE REVIEWED THE CURRENT PRIVACY NOTICE.

The following are the individuals that I permit to receive information regarding my care.

_____ _____ _____

ASSIGNMENT OF BENEFITS

I certify that I (or my dependant) have insurance coverage as listed above and assign directly to WSM all insurance benefits and payments that I am eligible for under my insurance for services rendered. I understand that I am responsible for all charges, whether covered by insurance or not. I also hereby authorize WSM to release all information necessary to third parties to secure the payment of claims. I authorize the submission of this assignment to insurers and third parties as part of the claim(s) submission and payment collections.

Responsible Party Signature _____ Date _____ Relationship to Patient _____

MEDICARE AUTHORIZATION

I request that payment of Medicare benefits be made either to me or on my behalf to WSM for any and all services furnished to me by WSM. I authorize any holder of PHI to release as needed to the Centers for Medicare and Medicaid Services and its agents for benefits determination or payment for rendered services. If "other health insurance" is indicated in Item 9 of the HCFA 1500 form, or on any other claim form/electronically submitted claim, I am also authorizing release of PHI to the insurer or agent shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and deductibles are based upon the determination of the Medicare carrier.

Beneficiary Signature _____ *Date*

WESTMORELAND SLEEP MEDICINE

CHILD SLEEP QUESTIONNAIRE
2-18 YEARS

Patient's name: _____ **Date:** _____

Referring Physician: _____ **Age:** _____

Please think about the past 3 months when answering the following questions:

WEEKDAY SLEEP SCHEDULE

1. What time does your child go to bed on *week nights* (school nights)? _____PM/AM
2. What time does your child wake up on *weekday mornings* (school mornings)? _____PM/AM
3. On averages, how many hours does your child sleep on school nights? _____hours
4. On how many *weekday mornings* (school mornings) does your child:
   - _____ wake up on his/ her own?
   - _____ use an alarm clock to wake up?
   - _____ need to be awakened by a parent, sibling or other caretaker?
   - _____ need to be awakened several times before getting out of bed?
5. How much does your child's bedtime and wake-up time change from night to night?

   _____ Less than 15 Minutes _____15 to 30 minutes _____30 to 60 minutes _____ More than 60 minutes

WEEKEND/ VACATION SLEEP SCHEDULE

1. What time does your child go to bed on *weekends* (non-school nights)? _____PM/AM
2. What time does your child wake up on *weekends* (non-school mornings)? _____PM/AM
3. On average, how many hours does your child sleep on *weekend* (non-school) nights? _____hours
4. Do you wake your child in the mornings? _____Yes _____No

Please indicate the best answer to each question by placing a check mark (√) in the appropriate box.	Never	Not during the past month	Less than once a week	Once or twice a week	3 or 4 times a week	5 or more times a week
1. Does your child have difficulty falling asleep at night?						
2. Does your child resist going to bed?						
3. How often is there a regular bedtime routine in your home?						
4. After bedtime, does your child call you back to the bedroom more than 2 times?						
5. Are bedtime and the hour leading up to it a stressful time?						
6. Does your child wake up in the middle of the night and take 10 or more minutes to fall back to sleep?						
7. Does your child grind his/her teeth while asleep?						
8. Does your child sleep in a caretaker's bed?						
9. Does your child share a bedroom with another family member?						
10. Do you observe your child while he/she sleeps?						
11. Does your child have repetitive movements during sleep? (check all that apply): ____leg jerks; ____head banging; ____lip smacking; or ____other _____and, how often:						
12. Does your child report having nightmares or frightening dreams?						
13. Does your child wet the bed at night? _____Yes; _____No						
14. Does your child report having very real dreams that there is a person or animal in his/her room?						
15. Does your child complain of leg pain or discomfort or feel the need to move his/her legs when at rest?						
16. Does your child snore?						
17. While your child is sleeping, does he/she (check all that apply): ____struggle to breathe; _____hold his/her breath; _____stop breathing for short periods of time; _____gasp; _____none of these?						
18. Does your child have difficulty waking up in the morning?						
19. Does your child experience headaches upon waking up?						
20. How often does your child nap? If your child naps, how long? _____						

25. If your child were to set his/her own schedule, which would he/she prefer? (Think about sleep habits during the summers and weekends.):

_____ Go to bed early and wake up early

_____ Go to bed late and wake up late

_____ Has no preference

26. Has you child ever taken over-the-counter or prescription medications at bedtime that help him/ her to calm down and/ or fall asleep? _____Yes _____No

If yes, please list medications and dose: _____

27. Which of the following items does your child have in his/ her bedroom?

_____Television; _____VCR; _____Computer; _____Internet access; _____Video game system

28. Does your child drink caffeinated beverages or eat foods that contain caffeine? _____Yes _____No

29. What is the longest time it has taken your child to fall asleep after being put to bed? _____minutes

30. How much time does it usually take him/her to fall asleep after being put to bed? _____ minutes

31. What is the longest time it has taken your child to fall back to sleep after awaking at night? _____minutes

32. Does your child wake up screaming, agitated or confused?

If yes, does he/she calm down after being comforted? _____Yes _____No

If yes, does he/she recall the awakening the next morning? _____Yes _____No

33. Does your child sleep walk?

If yes, during sleep walking episodes has he/she ever (check all that apply)?

_____been injured; _____been at risk of injury; _____attempted to leave the room;

_____attempted to go outside the home?

34. If you child wets the bed, has your child ever been completely dry for more than a week? _____Yes _____No

36. What are the chances that your child would doze in each of the following situations? (Please check (√) one box in each row:	**Would never doze**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
36a. In school (while in the classroom)				
36b. Watching television				
36c. Sitting quietly in public (in church, at a movie or lecture)				
36d. Riding in a car				
36e. Lying down to rest in the afternoon				
36f. While sitting and talking to someone				
36g. While playing alone quietly or reading				