DREAM IN DEL MAR
1349 CAMINO DEL MAR, SUITE F
DEL MAR, CA 92014
(858)755-1166 (888)399-9098

PATIENT INFORMATION

NAME:____ DOB:_____________
HOME PHONE:_________________________ CELLPHONE:_____________________
ADDRESS:____
CITY:________________________ STATE:________________
ZIP:_______________
EMPLOYER:________________________________ WORKPHONE:______________
EMAIL:____
SOCIAL SECURITY NUMBER:_________-_________-_________

INSURANCE INFORMATION

PRIMARY PLAN_______________________________ ID#______________________
GROUP#___________________________ SUBSCRIBER:______________________
SECONDARY PLAN___________________________ ID#_______________________
GROUP#___________________________ SUBSCRIBER:______________________

EMERGENCY CONTACT:

(TO PROVIDE SERVICES WE MUST HAVE AN ALTERNATE CONTACT)

NAME:___________________________ CONTACT PHONE:_____________________
RELATIONSHIP:_______________________ EMAIL:___________________________

DO YOU AUTHORIZE SMS TO RELAY PRIVATE PATIENT INFORMATION TO YOUR EMERGENCY CONTACT OTHER THAN A REQUEST FOR A CALLBACK IN THE EVENT WE CANNOT GET AHOLD OF YOU OR YOUR NUMBER HAS CHANGED?

____YES ____NO

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HEALTH AND HISTORY QUESTIONNAIRE

HEIGHT:_____in WEIGHT:_______ WEIGHT LAST YEAR:________
WAIST:_______ NECK SIZE:_______in

LIST ANY DIAGNOSED MEDICAL OR PSYCHIATRIC CONDITIONS:

Date of onset:	Condition:
____________________	____
____________________	____
____________________	____
____________________	____
____________________	____
____________________	____
____________________	____

LIST ANY MEDICATIONS OR SUPPLEMENTS CURRENTLY TAKING:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Drug Allergies:____

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EPWORTH SLEEPINESS SCALE

Please use the following scale to choose the most appropriate number for your situation.
0= Would never doze 1=Slight chance of dozing 2=Moderate 3= High (check one)

Sitting and Reading	0____	1____	2 ____	3____
Sitting inactive in a public place	0____	1____	2 ____	3____
As a passenger in a car for a hour w/o a break	0____	1____	2 ____	3____
Lying down to rest in the afternoon	0____	1____	2 ____	3____
Sitting talking to someone	0____	1____	2 ____	3____
Sitting quietly after lunch w/o alcohol	0____	1____	2 ____	3____
In a car while stopped for a few minutes in traffic	0____	1____	2 ____	3____
Watching TV	0____	1____	2 ____	3____

With the help of a bed partner please mark X next to the following as it applies to a typical night.

Snoring	____Nightly____Weekly____Rarely____Never
Observed pauses in breath	____Nightly____Weekly____Rarely____Never
Restless or interrupted sleep	____Nightly____Weekly____Rarely____Never
Awaken short of breath or gasping	____Nightly____Weekly____Rarely____Never
Difficulty falling asleep	____Nightly____Weekly____Rarely____Never
Leg or body jerks	____Nightly____Weekly____Rarely____Never
Teeth grinding	____Nightly____Weekly____Rarely____Never
Vivid Dreams	____Nightly____Weekly____Rarely____Never
Headaches	____Nightly____Weekly____Rarely____Never
Acid Reflux/ Indigestion	____Nightly____Weekly____Rarely____Never
Night Sweats	____Nightly____Weekly____Rarely____Never
Heart Palpitations	____Nightly____Weekly____Rarely____Never
Frequent nighttime urination	____Nightly____Weekly____Rarely____Never

Do you wake up refreshed ____Yes ____No
Dry mouth in the morning ____Yes ____No
Sore Jaw in the morning ____Yes ____No

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Do you smoke? ____Yes ____No Packs per day? ______
Do you drink Alcohol? ____Yes ____No Drinks per day? ______

Do you have any metal, surgical clips, stents, plates in the body or head or a pace maker? ____Yes ____No If yes what kind:___________________________

Are you Pregnant? ____Yes ____No

Please describe briefly what problems you were referred her for:

____
____
____
____

______________________________________ ________________________
Signature/Typed Name Date

THANK YOU FOR CHOOSING DREAM IN DEL MAR FOR YOUR SLEEP NEEDS!

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RELEASE OF MEDICAL INFORMATION

Patient:____ DOB:_______________

I AUTHORIZE any holder of my records to release my medical information pertaining to my diagnosis for which I am receiving treatment from DREAM IN DEL MAR.

Please list Physician you would like us to request your medical records from.

Name:______________________________________ Phone:___________________
Fax:_________________

Name:______________________________________ Phone:___________________
Fax:_________________

____ _____________________
Signature/Typed Name Date

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INSURANCE CONSENT FORM

I ____ authorize Dream in Del Mar and its affiliates to bill my ____ plan for these services rendered. I also have ____ as a secondary coverage that I am requesting be billed for my out of pocket expense if applicable.

I understand that I am responsible for paying a sum of $__________ that will be applied to my yearly deductible and I understand that this amount is non-refundable in the event my insurance denies my services for medical necessity.

I understand that Dream in Del Mar and the affiliates are Non-Participating providers with my insurance company and that I am responsible of a coinsurance, not to be confused with my deductible at the rate of _______% or quoted amount not to exceed $_______ if applicable.

*I also understand that at any time my insurance plan can request medical documentation for the services provided and if they find that these services were not medically necessary based on my physician documentation, I may be billed for the services I received at a cash rate, less what I paid up front.

*I also agree and am aware that prior to all services benefits are checked and prior authorizations is obtained if needed. I understand that this is not a guarantee of payment and may be billed for services denied as stated above.

*I understand that I may receive checks from my insurance plan and that is the insurance portion. Payment, not to be confused with any deductible or co-insurance that I am responsible for.
*Please note - Checks are mailed to the address your plan has on file, if you do not receive correspondence from your insurance, please contact them immediately to ensure they have the correct address for you, on file. Checks are due within 14 days of the date you receive your invoice, if payment is not received within 14 days, you are eligible for a late fee of $50.00 to be added to your balance.

____ ______________

Signature/Typed Name Date

Initials _________