The Regional Center for Sleep Medicine

INITIAL CONTACT FORM

Date ____/____/____

Patient Name:_____
Last First Initial

Address:_____
Street City, State, Zip

Phone Number (Home):_____ **Work:**_____

Social Security #:_____ /____ /_____ **E-Mail Address:**_____

Date of Birth: _____ /_____/_____ **Sex:** Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

Race: White ☐ Black ☐ Other ☐ _____

Occupation:_____

Employed by:_____

Emergency Contact/Relationship:_____

Emergency Contact Phone Number: _____

Referred by: _____
Name Office Phone Number Fax Phone Number City, State, Zip

PCP: _____
Office Phone Number Fax Phone Number City, State, Zip

Reason:_____

Have you been a patient before? Yes ☐ No ☐

Sleep Complaint:_____

_____ **Duration:**_____

Do you snore? Yes ☐ No ☐ **If yes, how loud is it?**_____

General Health: _____