Lung & Wellness Centers

Natrona Heights Sleep Center
An affiliate of Center Pointe Sleep Associates, LLC.
1830 Union Ave, Suite B
Natrona Heights, PA 15065
Phone 724-904-7794

Fax 724-904-7776

Lab Location: Natrona Heights

Date(s) of Study: ____________________ _____________________

It is very important that these forms be returned with your study. Please fill out the information and send it back with your unit. If you have any questions on the enclosed materials, please feel free to contact us. Thank you.

PATIENT REGISTRATION FORMS

Name: ____________________________________ DOB: _____________
Address: __________________________________ City: _________________ State: _____ Zip: _________
Phone: _______________________ Alternate Phone: _________________

☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor

Height _______ Weight ______ Approximate Bedtime: __________ pm/am Waketime: _________ pm/am
Do you take a sleep aide: ☐ Yes ☐ No **(If this is your normal routine your physician may want you to take one for the study.)**

Referring Doctor: ________________________________ Phone: ______________________
Primary Care Physician: ___________________________ Phone: ______________________

INSURANCE

PLEASE BRING YOUR CARDS WITH YOU

Primary Insurance: _______________________________ ID# ______________________ Group # _______________
Phone #: ____________________________ Address____
Subscriber: ☐ Self ☐ Parent ☐ Spouse Name: __________________________ DOB ________________

Secondary Insurance: _____________________________ ID# ______________________ Group # _______________
Phone #: ____________________________ Address____
Subscriber: ☐ Self ☐ Parent ☐ Spouse Name: __________________________ DOB ________________

DME/EQUIPMENT INFORMATION

Do you presently have a Durable Medical Equipment Company who provides medical equipment to you or any family member in your home? ☐ Yes ☐ No **If Yes**, name of DME Company: ____________________________

Type of equipment currently being used: _________________________

If you are currently on oxygen, how many liters are you on? ________ ☐ Day ☐ Night ☐ Both

If you are currently using equipment, please bring your mask/nasal cannulas and tubing with you for the study.

Patient Signature: ______________________________________ Date: _____________________