Park Sleep Medicine

PATIENT INFORMATION

Date:_____

First Name:_____ Middle Name:_____ Last Name:_____

Address:_____

Date of Birth:_____ Age:_____ Gender:_____

Home Phone #:_____ Work Phone #:_____Ext:_____

Cell Phone #:_____ Employer:_____

Occupation:_____ Spouse/Guardian:_____

INSURANCE

Primary Insurance:_____ Co-pay amount:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Insurance ID #:_____

Group #:_____

Secondary Insurance (if applicable):_____ Co-pay amount:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Insurance ID #:_____

Group #:_____

REFERRAL INFORMATION

Referring Physician:_____

Address:_____

Phone #:_____ Fax #:_____

Primary Care Physician:_____

Address:_____

Phone #:_____ Fax #:_____

Referred by (if other than physician):_____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone #:_____

I authorize Park Sleep Medicine to release my medical records to my insurance company and other medical providers.

Signature:_____Date_____

PLEASE READ CAREFULLY!

We will bill your insurance for you, providing that you supply Park Sleep Medicine with complete and current billing information. Any balance after insurance has paid is your responsibility and is due and payable upon receipt of our statement.

Insurance co-pays are due at the time of service.

Many insurance companies require referrals from your primary care doctor prior to your appointment with us. Please check with your insurance carrier. **If a referral is required, please contact your primary care doctor to send one to us before your first appointment.**

Some insurance policies do not include coverage for sleep disorders. **Please call your insurance carrier before your appointment to check your benefits so that you have advance knowledge of your financial responsibility.**

Office visits and sleep studies involve a large commitment of resources. Missed appointments and sleep studies waste resources that can be used for the care other patients and increase the cost of medical care for everyone. **If you cannot come in for an appointment or study, please contact us at least 24 hours in advance to allow us to fill your slot.**

If you do not show or cancel your appointment at least 24 hours in advance, there will be a $50.00 no-show/cancellation fee.

Please contact your pharmacy directly for refills. **Refills will be processed within 3 business days from when your pharmacy contacts us.**

I have read and understood the above information. I understand that a $25.00 fee will be added to my account in the event of a returned check due to insufficient funds. I authorize my insurance benefits to be paid directly to Park Sleep Medicine. I also authorize the release of any information required by my insurance carrier to process medical claims. If I am prescribed Durable Medical Equipment (DME), such as a CPAP machine, I am aware that I have a choice in companies from which I can receive my equipment.

Signature:_____ Date:_____

MEDICARE PATIENTS ONLY

Park Sleep Medicine bills Medicare directly. You are responsible for you annual deductable and 20% co-insurance. Most secondary insurances will pick up these fees.

I authorize Park Sleep Medicine to release to the US Federal Government, or its designated agent, any information needed to process my medical claims. I permit a copy of this authorization to be used in place of the original and request payment of insurance benefits be made to my healthcare provider if assignment is accepted.

Signature:_____ Date:_____

PARK SLEEP MEDICINE

Please fill out all 4 pages of this form as completely as possible. Thank you.

Name_____ Date_____ Age_____ Gender_____ What is your occupation?_____

Highest level of education_____ Marital status_____ Number of children (with ages)_____

In your own words, please list your main sleep problems and estimate how long you had each problem.

1._____

2._____

Previous sleep diagnosis (please list all)_____ Year(s) diagnosed_____

Name and address of diagnosing doctor_____

Have you had a sleep study before? Yes_____ No_____ Year(s)_____

Name and address of center where study was done_____

Please check any/all treatments you currently use for your sleep problems.

CPAP_____ **BiPAP**_____ Setting_____ When did you first start using CPAP/BiPAP?_____

Name and address of CPAP/BiPAP supplier_____

How many nights a week do you use CPAP/BiPAP?_____ How many hours each night?_____

Problems with CPAP/BiPAP_____ Is CPAP/BiPAP effective?_____

Oral appliance_____ When did you first start using an oral appliance?_____

Name and address of person who made your oral appliance_____

How many nights a week do you use your oral appliance?_____ How many hours each night?_____

Problems with oral appliance_____ Is the oral appliance effective?_____

Oxygen_____ Setting_____ When did you first start using oxygen?_____

Name and address of prescribing doctor_____

Name and address of oxygen supplier_____

How many nights a week do you use oxygen?_____ How many hours each night?_____

Problems with oxygen_____ Is oxygen effective?_____

Surgery for sleep apnea_____ Year(s) of surgery_____

Name and address of surgeon(s)_____

Problems with surgery_____ Is surgery effective?_____

Medications for sleep problems (name and dose):_____

Date(s) medications started_____ how many times a week used_____

Name and address of prescribing doctor(s)_____

Problems with medications_____ Are medications effective?_____

What medications have you tried in the past for sleep problems?_____

Why did you stop taking these medications?_____

Please answer the following questions about your sleep habits.

Workdays (example Monday-Friday)_____ Work hours_____

Workdays: Bed time_____ How long to fall asleep_____ Final wake time_____

Number of times awake in the night_____ Reason for awakening_____ Average time awake each time_____

Naps per day (include times dozing off)_____ Average length of naps_____

Non-workdays: Bed time_____ How long to fall asleep_____ Final wake time_____

Number of times awake in the night_____ Reason for awakening_____ Average time awake each time_____

Naps per day (include times dozing off)_____ Average length of naps_____

Ideal bedtime_____ Ideal wake time_____

How long have you had this sleep schedule?_____

Do you have a bed partner? Yes____ No____ Is the head of your bed elevated? Yes___ No___ If so, how much?_____

Do you sleep out of your bed? Yes____ No____ If so, where?_____ How many times a week?_____

Have any of your blood relatives (parents, children, siblings, cousins, grandparents, uncles/aunts) had any of the following conditions?

Obstructive sleep apnea_____ Insomnia_____ Parkinson's disease_____

Loud snoring_____ Restless legs_____ Depression_____

Excessive sleepiness_____ Heart disease_____ Anxiety_____

Narcolepsy_____ Epilepsy or seizures _____ Attention deficit/hyperactivity_____

Other (please list)_____

Current medical problems (diabetes, high blood pressure, heart disease, COPD, depression, etc)

1_____ 2_____

3_____ 4_____

5_____ 6_____

7_____ **Are you pregnant?** Yes_____ No_____ N/A_____

Past medical problems and year of occurrence (surgeries, accidents, head injury, depression, etc)

1_____ 2_____

3_____ 4_____

5_____ 6_____

7_____ 8_____

Current medications, vitamins and supplements (please list doses)

1_____ 2_____

3_____ 4_____

5_____ 6_____

7_____ 8_____

Medication and food allergies

1_____ 2_____

3_____ 4_____

5_____ 6_____

Personal habits/information

Do you smoke or use chew tobacco? Yes____ No____ If so, how much PER DAY?_____ How long have you used tobacco?_____

Do you drink alcohol? Yes__ No__ If so, how many drinks PER WEEK?_____ Have you had treatment for alcohol dependence? Yes__ No__ Year____

Do you drink caffeinated beverages (soda, coffee, tea, energy drinks)? Yes____ No____ If so, how much PER DAY?_____

Do you use recreational drugs (marijuana, etc) Yes__ No__ If so, what do you use and how much?_____

Have you had treatment for drug dependence? Yes____ No____ Year_____

Weight (pounds)_____ Height (feet/inches)_____ Neck/collar size (inches)_____

Weight loss or gain in the past year (pounds)_____ Weight loss or gain the in past 5 years (pounds)_____

Please estimate the likelihood of nodding off or falling asleep in the following scenarios using a 0 – 3 scale.

0	1	2	3
Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Sitting, inactive, in a public place (theater, meeting, etc)	
Passenger in a car for an hour without a break	
Lying down in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch (assume no alcohol with lunch)	
In a car, while stopped for a few minutes in traffic	
Watching TV	

_____/24

Please indicate how often you have experienced the following symptoms recently using the scale below. Please ask your bed partner to help.

0	1	2	3	4
Never	Rarely (less than once a month)	Occasionally (1-3 times a month)	Frequently (1-3 times a week)	Daily or almost daily

1.

Snoring 0 1 2 3 4

Breathing stops while asleep 0 1 2 3 4

Breathing alternates between shallow and deep while asleep 0 1 2 3 4

Awakened by gasping or chocking 0 1 2 3 4

Night sweats 0 1 2 3 4

Wake up with heartburn without medication 0 1 2 3 4

Wake up with a dry mouth 0 1 2 3 4

Urinating more than once per night 0 1 2 3 4

Headaches in the morning when you wake up 0 1 2 3 4

2.

Restless/uncomfortable feelings in legs or arms 0 1 2 3 4

Urge to move arms or legs while staying still 0 1 2 3 4

Urge to move interferes with getting to sleep 0 1 2 3 4

Twitching or jerking of limbs while asleep 0 1 2 3 4

3.

Sudden temporary muscle weakness brought on by emotion 0 1 2 3 4

Unable to move body while waking up or falling asleep 0 1 2 3 4

Hallucinations or dreamlike images falling asleep or awakening 0 1 2 3 4

Fall asleep while holding a conversation or engaged in an activity 0 1 2 3 4

4.

Waking up to eat or drink at night, more than just a sip of water	0 1 2 3 4
Walking around in sleep without remembering	0 1 2 3 4
Acting out dreams while asleep	0 1 2 3 4
Making angry or frightened sounds while sleeping	0 1 2 3 4
Making angry or frightened movements while sleeping	0 1 2 3 4
Talking, yelling or groaning while asleep	0 1 2 3 4

5.

Not feeling rested in the morning when you wake up	0 1 2 3 4
Sleepiness interferes with work or school	0 1 2 3 4
Sleepiness makes it difficult to drive	0 1 2 3 4
Sleepiness interferes at home or social life	0 1 2 3 4
Fall asleep watching TV	0 1 2 3 4
Fall asleep on couch or recliner	0 1 2 3 4

6.

Difficulty learning new things	0 1 2 3 4
Difficulty getting organized	0 1 2 3 4
Overwhelmed by complicated tasks	0 1 2 3 4
Difficulty staying focused at work or school	0 1 2 3 4

7.

Feeling down or blue much of the day	0 1 2 3 4
Decreased interest in social activities	0 1 2 3 4
Feelings of guilt or remorse	0 1 2 3 4
Changes in appetite	0 1 2 3 4
Irritable much of the day	0 1 2 3 4
Easily upset	0 1 2 3 4
Impatient with others	0 1 2 3 4
Loss of temper/anger outbursts	0 1 2 3 4

8.

Anxious, nervous or edgy much of the day	0 1 2 3 4
Easily startled	0 1 2 3 4
Fear of being in tight/enclosed spaces	0 1 2 3 4
Nightmares or disturbing dreams	0 1 2 3 4
Recurrent obsessive thoughts	0 1 2 3 4
Panic attacks in the middle of the night	0 1 2 3 4

9.

Thoughts won't quiet down at bedtime	0 1 2 3 4
Takes longer than an hour to get to sleep without medication	0 1 2 3 4
Wake three or more times per night	0 1 2 3 4
Can't get back to sleep if awakened	0 1 2 3 4
Frustrated because of inability to sleep	0 1 2 3 4

10. Men only

Problem obtaining or maintaining erections	0 1 2 3 4
Awakening with painful erections	0 1 2 3 4

11. Women only

Awakened by painful menstrual cramps	0 1 2 3 4
Sleep problems related to menstrual cycle	0 1 2 3 4
Sleep problems related to menopause	0 1 2 3 4

12.

Stuffy or runny nose	0 1 2 3 4
Sinus fullness or pain	0 1 2 3 4
Tooth grinding or clenching	0 1 2 3 4
TMJ/jaw joint pain	0 1 2 3 4
Sore throat/hoarseness	0 1 2 3 4

13.

Wheezing	0 1 2 3 4
Coughing	0 1 2 3 4
Shortness of breath	0 1 2 3 4
Rapid or irregular heartbeat	0 1 2 3 4
Swelling of limb (edema)	0 1 2 3 4
Chest pain or heaviness	0 1 2 3 4

14.

Abdominal pain or cramping	0 1 2 3 4
Diarrhea	0 1 2 3 4
Bloating or Belching	0 1 2 3 4

15.

Achy joints	0 1 2 3 4
Achy or tender muscles	0 1 2 3 4
Awakened by pain	0 1 2 3 4
Pain interferes with going to sleep	0 1 2 3 4

Driving Precautions Acknowledgement

1. I agree not to drive if I am sleepy.

2. If I am sleepy while driving, I will immediately get off the road and stop driving until I am no longer sleepy or have someone who is not impaired do the driving for me.

3. I understand that the most effective, but not always effective, method to reduce sleepiness is to take a nap.

4. I understand that most other activities will not lessen sleepiness including but not limited to walking around, chewing gum, opening the window, turning on the AC and turning on the radio.

_____	_____	_____
Signature	Print Name	Date