**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:** Single Married Widowed Divorced  **Social Security Number \_ \_ \_ \_ - \_ \_ - \_ \_ \_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other/Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER INFORMATION**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU THE POLICY HOLDER: Yes\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_ (if no, please complete section below)?**

**POLICY HOLDER INFORMATION**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of Emergency, Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To Whom Can Medical Records be released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize Suburban Pulmonary and Sleep Associates as a holder of Medical Information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Suburban Pulmonary and Sleep Associates and authorize Suburban Pulmonary and Sleep Associates to submit claims on my behalf for any bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION FOR TREATMENT**

**I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the Physician and/or his Healthcare providers.**

**CONSENT TO OBTAIN MEDICATION HISTORY**

**I authorize Suburban Pulmonary & Sleep Associates to obtain my medication history from my pharmacy. This consent includes any prescription medications used to treat AIDS/HIV, mental health or psychiatric conditions. This information will become part of your medical record.**

**RELEASE OF INFORMATION**

**I authorize the facility to release to my insurance carrier or its designated agents any information concerning medical care (physical or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of valid as the original. I will notify the facility in writing of any information I do not want released.**

**ASSIGNMENT OF INSURANCE BENEFITS**

**I authorized the assignment of benefits payable to Suburban Pulmonary and Sleep Associates, LTD, and/or its designees for Physician services and supplies by government and or any other private third-party payer. I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.**

**FINANCIAL POLICY**

* **Co-payments are required by your insurance to be paid at the time of check in for your appointment. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office as it is an insurance requirement. We accept cash, checks or credit cards. Our office does not bill for co-pays. If you are unable to pay at the time, your appointment will be rescheduled.**
* **Self-Pay accounts are required to be paid at the time of check-out after your office visit has been completed. All services that were provided at the time of service must be paid in full.**
* **Workman’s Compensation and Motor Vehicle Accidents: It is the responsibility of the patient to advise this office if their injury is work related. You must provide this office with your employer’s name, address, phone number. Additionally, you will provide this office with the worker’s compensation insurance carrier’s name, phone number, and claim number. Patients involved in a motor vehicle accident are responsible for presenting their individual group health insurance information; the patient will be responsible for submitting all claims to the responsible parties’ insurance. This office does not submit third party insurance claims.**
* **Insurance:**
* **It is the patient’s responsibility to confirm with our office and the insurance company that the physician is currently under contract with your plan.**
* **Insurance cards are required at each visit. If there are any changes to your insurance including, but not limited to, new insurance identification number and/or group number, it is the responsibility of the patient to inform this office immediately.**
* **If your plan requires a referral prior to seeing a specialist, please contact your primary care physician and bring the referral with you to your appointment. Failure to bring the necessary referral will cause your appointment to be rescheduled.**
* **Our office will bill all insurance companies for the services provided. Upon response of insurance, you will be sent a statement stating your payment responsibility. Our office requires balances to be paid within 30 days of receiving the billing statement.**

**I agree to pay any outstanding balances within 30 days after receiving a statement from Suburban Pulmonary and Sleep Associates, LTD, notifying me of such balance.**

**ADDITIONAL FEES**

**If any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for all costs not limited to attorney’s fees, court costs, collection fees, interest and any additional costs that this action may occur.**

**No Show Appointment: an appointment is considered a “no show” when there is neither a phone call nor appearance at the scheduled appointment time. There is no charge for the first occurrence. Second or subsequent occurrences of a no-show appointment are subject to a $50.00 charge per occurrence which is not covered by insurance**

**Form completion: There will be a fee of $40 per packet for completion of FMLA (Family and Medical Leave Act) and/ or other forms. This is to be paid prior to form completion and is not billed to the insurance company. However, patients requesting a Disability Form be completed by a physician will require an extended office visit with their physician for completion. Disability forms will not be completed without an office visit. There is no form completion charge for disability forms as it is specifically covered in the office visit.**

**UNCOOPERATIVE PATIENTS**

**Physicians are not required to continue treatment of a patient who is uncooperative, refuse to follow treatment advice and/or presents difficulties in the doctor-patient relations. Our goal is to try to accommodate all our patients’ needs. Demanding and abusive language toward our physicians or staff does not help us meet that goal. Patients may be dismissed from our practice for non- compliance.**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES FROM**

**I HEREBY ACKNOWLEDGE receipt of the Physician’s Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Practice may use and disclose my confidential information. I understand that the Physician has reserved a right to change his or her privacy Practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available for any review at all Suburban Pulmonary and Sleep Associates, LTD, locations.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature of Patient/Guarantor Print Name of Patient/Guarantor**

 **Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES**

 **NO KNOWN ALLERGIES**

**LIST ANY MEDICATION ALLERGIES OR ADVERSE REACTIONS:**

|  |  |
| --- | --- |
| **DRUG** | **REACTION** |
|  |  |
|  |  |
|  |  |
|  |  |
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**MEDICATIONS**

**Please list all medicines that you are CURRENTLY taking:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSE** | **FREQUENCY** |  | **MEDICATION** | **DOSE** | **FREQUENCY** |
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**IMMUNIZATIONS**

|  |  |
| --- | --- |
| **IMMUNIZATION** | **DATE of MOST RECENT** |
|  |  |
| **Influenza/Flu** |  |
| **Pneumovax** |  |
| **Prevnar 13** |  |

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_/\_\_/\_\_\_\_**

**Work Status: Full time/ Part time/ Self-Employed/ Retired/ Other\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History (Check all items that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No** | **Yes** | **If yes, fill out below** |
| **Do you currently smoke cigarettes?** |  |  | **Average packs per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Number of years smoked total\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Did you smoke in the past?** |  |  | **Year quit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Average packs per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Number of years smoked total\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you use recreational drugs? (including marijuana)** |  |  | **Type of drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date last used\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you drink alcoholic beverages?****Have you ever been treated for dependency?** |  |  | **Type of alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Average per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you use caffeine? (Coffee, soda, Tea, Pills)** |  |  | **Type of caffeine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Average per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |
| **When was your last TB skin test?** |  |  | **N/A \_\_\_\_\_\_\_\_\_****Date \_\_\_/\_\_\_/\_\_\_\_****Results:**  **Positive Negative** |

**PAST MEDICAL HISTORY:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | NO |  |  | **YES** | NO |
| Arthritis |  |  |  | Heartburn |  |  |
| Asthma |  |  |  | Kidney Disease |  |  |
| Atrial Fibrillation |  |  |  | Narcolepsy |  |  |
| Blood Clots(legs, lungs, other) |  |  |  | Parkinson’sDisease |  |  |
| [ ]  DVT |  |  |  | Pulmonary Fibrosis |  |  |
| [ ]  Pulmonary Embolism |  |  |  | Pulmonary Hypertension |  |  |
| Cancer (type\_\_\_\_\_\_\_\_\_\_) |  |  |  | Sarcoidosis |  |  |
| Congestive Heart Failure |  |  |  | Seizures |  |  |
| Coronary Artery Disease: |  |  |  | Sinus Disease |  |  |
|  Bypass surgery  Date: \_\_\_\_\_\_\_\_\_ |  |  |  | Sleep Apnea |  |  |
|  Heart Attack Date: \_\_\_\_\_\_\_\_\_\_ |  |  |  | Stroke |  |  |
|  Stent placed Date: \_\_\_\_\_\_\_\_\_\_ |  |  |  | Thyroid Disease:Overactive (hyper) |  |  |
| Diabetes (type I or II) |  |  |  | Thyroid Disease:Underactive (hypo) |  |  |
| Emphysema |  |  |  |  |  |  |
| Fibromyalgia |  |  |  | Other: |  |  |
| High Blood Pressure |  |  |  |  |  |  |

**FAMILY MEDICAL HISTORY (CHECK ALL ITEMS THAT APPLY)**



**PAST SURGICAL HISTORY (PLEASE LIST SURGERIES AND YEARS PERFORMED)**





# Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. THE EPWORTH SLEEPINESS SCALE:** How likely are you to doze off or fall asleep in the following

situations, in contrast to feeling just tired. (This refers to your usual way of life in recent times. Even if you have no done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation)

#  SCALE: 0 = NEVER 1= SLIGHT 2= MODERATE 3= HIGH

|  |  |
| --- | --- |
| **SITUATION** | **CHANCE OF DOZING?**  |
| Sitting and reading | □0 □1 □2 □3 |
| Watching TV | □0 □1 □2 □3 |
| Sitting, inactive in a public place (e.g. a theater or a meeting) | □0 □1 □2 □3 |
| As a passenger in a car for an hour without a break | □0 □1 □2 □3 |
| Lying down to rest in the afternoon when circumstances permit | □0 □1 □2 □3 |
| Sitting and talking to someone | □0 □1 □2 □3 |
| Sitting quietly after a lunch without alcohol | □0 □1 □2 □3 |
| In a car, while stopped for a few minutes in traffic | □0 □1 □2 □3 |
| **TOTAL: add up your answers**  |  |

|  |
| --- |
| **1. Do you have any of the following problems?**  Narcolepsy  Periodic limb movements  Sleep walking  Restless legs syndrome  Sleep terrors  Insomnia  Sleep apnea  If yes, how is it managed:   Oral Appliance   CPAP Pressure Setting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   AutoPAP Pressure Setting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Bilevel Appliance Pressure Setting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How often do you use your appliance/PAP unit?   Almost every night  Every night   Infrequently  Rarely |
| 3. Typical amount of time to fall asleep \_\_\_\_\_\_\_\_ minutes  \_\_\_\_\_\_\_\_hours  |
| 4. Do you take medication to fall asleep?  NO  YES If Yes, the name of the medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 5. What is your estimated daily caffeine intake? (cups of coffee, tea, energy drinks): |
| 6. How many times do you wake up during the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 7. How many times do you urinate during the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
| 8. Typical time you go to bed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 10. Typical time you awaken each day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|   11. Number of naps per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 12. Do you wake up  Refreshed  Unrefreshed   |
| 13. Do your legs or arms feel “funny”, tingly, or restless?  NO  YES  If yes, Is it worse when tired?  NO  YES Is it worse before going to sleep  NO  YES? Does it cause insomnia?  NO  YES  |
| 14. How many nights per week do you recall having a dream? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you consider your dreams vivid, at times thinking they are real?   NO  YES  |
| 15. Have you ever been in a car accident?  NO  YES If yes, were you drowsy or sleep at the time?  NO  YES |

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| 1. Do you have trouble falling asleep?  |  |  |
| 2. Do you drink alcohol to fall asleep?   |  |  |
| 3. Do you ever awaken feeling paralyzed, as if you cannot move for a few seconds? |  |  |
| 4. Do you have trouble staying asleep or feel you wake up too early?  |  |  |
| 5. Do you wake up with a headache?   |  |  |
| 6. Do you have night sweats?  |  |  |
| 7. Do you work night shifts?   |  |  |
| 8. Do you grind your teeth?  |  |  |
| 9. Do you ever wake up screaming?   |  |  |
| 10. Do you snore?   |  |  |
| 11. Has anyone ever told you that you stop breathing while asleep?  |  |  |

****