SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Date: ____________________

SLEEP PATIENT

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: ___________________________________ 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 __________________________

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

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.

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, coinsurance, 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: o 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.

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

No Show Appointment: an appointment is considered a "no show" when there is neither a phone call or 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 ________________________________

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name: ____ DOB ___________________

ALLERGIES

☐ NO KNOWN ALLERGIES

LIST ANY MEDICATION ALLERGIES OR ADVERSE REACTIONS:

DRUG	REACTION

MEDICATIONS

Please list all medicines that you are CURRENTLY taking:

MEDICATION	DOSE	FREQUENCY		MEDICATION	DOSE	FREQUENCY

IMMUNIZATIONS

IMMUNIZATION	DATE of MOST RECENT
Influenza/Flu	
Pneumovax	
Prevnar 13	

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name ____DOB __/__/____

Marital Status: Single/ Married/ Widowed/ Divorced

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?			Type___________________________________ Average packs per day_____________________ Number of years smoked total_______________
Did you smoke in the past?			Year quit_______________________
Do you use recreational drugs?			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_________________
	No	Yes	
When was your last TB skin test?			N/A _________ Date ___/___/____ Results: ☐ Positive Negative

Patient Name____DOB_____________

PAST MEDICAL HISTORY:

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

	YES			YES
No significant Medical History			Heartburn	
Arthritis			Kidney Disease	
Asthma			Narcolepsy	
Atrial Fibrillation			Parkinson's Disease	
Blood Clots (legs, lungs, other)			Pulmonary Fibrosis	
DVT			Pulmonary Hypertension	
Pulmonary Embolism			Sarcoidosis	
Cancer (type________________)			Seizures	
Congestive Heart Failure			Sinus Disease	
COPD			Sleep Apnea	
Coronary Artery Disease			Stroke	
CAB Surgery Date________________			Thyroid Disease -Overactive (Hyper)	
CAD Heart Attack Date ___________			Thyroid Disease -Underactive (Hypo)	
CAD Stent Date _________________				
Diabetes (Type I or II)			Other:	
Emphysema				
Fibromyalgia				
High Blood Pressure				

FAMILY MEDICAL HISTORY (CHECK ALL ITEMS THAT APPLY)

	YES			YES
No significant Family History			High Blood Pressure	
Asthma			Narcolepsy	
Blood Clots (legs, lungs, other)			Pulmonary Hypertension	
DVT			Sleep Apnea	
Pulmonary Embolism			Thyroid Disease -Overactive (Hyper)	
Cancer (type________________)			Thyroid Disease -Overactive (Hypo)	
COPD				
Coronary Artery Disease			Other:	
Diabetes (Type I or II)				
Emphysema				

PAST SURGICAL HISTORY (PLEASE LIST SURGERIES AND YEARS PERFORMED)

TYPE OF SURGERY	DATE		PROSTHESIS/ASSISTIVE DEVICES	YEAR
			Artificial Heart Valve	
			Artificial Joints	
			Dentures (Upper/Lower)	
			Defibrillator	
			Pacemaker	
			Walker/Cane/Wheelchair	
			Other:	

Patient Name____**DOB**______________

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Check all items that are existing or current complaints

Head/Eyes/Ears/Nose/Throat Complaints(HEENT)

- ☐ **No** HEENT Complaints
- ☐ Hearing Loss
- ☐ Cataracts
- ☐ Itching, Burning, or Dry Eyes
- ☐ Voice Changes/Laryngitis
- ☐ Nosebleeds
- ☐ Hay Fever
- ☐ Postnasal Drip
- ☐ Sinus Congestion
- ☐ Sinus Headaches
- ☐ Other ______________________________

Musculoskeletal/Skin Complaints

- ☐ **No** Musculoskeletal/Skin Complaints
- ☐ Rashes/Bruises/ Sores
- ☐ Muscle Pain
- ☐ Joint Pain/Swelling/Deformities
- ☐ Chronic Pain/Stiffness
- ☐ Back Pain
- ☐ Other______________________________

Neurological Complaints

- ☐ **No** Neurological Complaints
- ☐ Headache
- ☐ Seizures
- ☐ Weakness/Tingling/Numbness
- ☐ Fainting Spells
- ☐ Dizziness
- ☐ Other_____________________________

Cardiovascular Complaints

- ☐ **No** Cardiovascular Complaints
- ☐ Chest Pain/Angina
- ☐ Irregular Heart Rhythm/Palpitations
- ☐ Heart Murmur
- ☐ Swelling of ankles/Edema
- ☐ Short of breath lying flat
- ☐ Leg Cramps -Walking/Rest/Sleep
- ☐ Other____________________________
- ☐ Choking feeling
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other_______________________

Respiratory Complaints

- ☐ **No** Respiratory Complaints

Gastrointestinal Complaints

- ☐ **No** Gastrointestinal Complaints
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Heartburn or reflux symptoms
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool/bloody stool
- ☐ Other____________________________

Endocrine/Other Complaints

- ☐ **No** Endocrine Complaints
- ☐ Increased thirst
- ☐ Intolerant of heat
- ☐ Intolerant of cold
- ☐ Chronically tired or fatigued
- ☐ Low blood count or anemic
- ☐ Other___________________________

Genitourinary Complaints

- ☐ **No** Genitourinary Complaints
- ☐ Prostate Problems
- ☐ Incontinence during sleep
- ☐ Incontinence while coughing
- ☐ Other_______________________________

General Complaints

- ☐ **No** General Complaints
- ☐ Chills
- ☐ Fevers
- ☐ Sweats
- ☐ Weight gain in past year _______lbs
- ☐ Weigh loss in past year ________lbs
- ☐ Loss of appetite

Other________________________

Suburban Pulmonary and Sleep Associates LTD

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	

	NO	**YES**
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		

SLEEP HISTORY	NO	YES
2. Do you have trouble falling asleep?		
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. Do you drink alcohol to fall asleep?		
6. Do you have trouble staying asleep or feel you wake up too early?		
7. How many times do you wake up during the night? _______________		
8. How many times do you urinate during the night? _______________		
9. 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 you wake up with a headache?		
14. Do you have night sweats?		
15. Do you work night shifts?		
16. Do you grind your teeth?		
17. Do you ever wake up screaming?		
18. Do you snore?		
19. Has anyone ever told you that you stop breathing while asleep?		
20. 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		
21. Do you ever awaken feeling paralyzed, as if you cannot move for a few seconds?		
22. 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		
23. Have you ever been in a car accident? ☐ NO ☐ YES If yes, were you drowsy or sleep at the time? ☐ NO ☐ YES		

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name: ____ **DOB:** _______________

Date: ___________________________

I, ____ **have received a copy of this office's Notice of Privacy Practices.**

Signature: ____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining the acknowledgement**
- ☐ **Other (Please Specify)**

____

____

TWO-WEEK SLEEP DIARY: Please complete this sleep diary on the days preceding your appointment

Name (Print): ______________________________ Date of Birth: _________________________

1. Write the day of the week and date in the fields provided.
2. Use a down arrow to mark the time you got **into bed** (↓).
3. Use an up arrow to mark the time you got **out of bed** (↑).
4. Mark **W** if you were **awakened by an alarm or another person.**
5. Mark **S** if you **awakened on your own.**
6. **Shade** in the periods to show when you were **asleep**, including all naps.
7. Leave the periods **un-shaded** to show when you were **awake.**

Day	Date	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1p	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	12am
Thu	**1-26**								↑ W							↑ W						↓				
Fri	**1-27**				S					↑ S				**(Example: 2 day record)**									↓			