



PLEASE PRINT

## PATIENT INFORMATION FORM

DATE: \_\_\_\_\_

LAST NAME	FIRST NAME	MIDDLE/MAIDEN	EMAIL ADDRESS
SEX	BIRTHDATE	SOCIAL SECURITY #	PATIENT EMPLOYER
STREET ADDRESS/ APT#		CITY	STATE ZIP CODE
HOME #	WORK#	CELL#	REFERRING DOCTOR
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED			
PRIMARY CARE DOCTOR		ADDRESS	TELEPHONE #

### INSURANCE

PRIMARY INS. CO	SUBSCRIBERS NAME	SS#
SUBSCRIBER IDENTIFICATION	GROUP NUMBER	DOB
RELATIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	SUBSCRIBERS EMPLOYER
SECONDARY INS. CO	SUBSCRIBERS NAME	SS#
SUBSCRIBER IDENTIFICATION	GROUP NUMBER	DOB
RELATIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	SUBSCRIBERS EMPLOYER

### Responsible Person for Account of Patient Under 18

NAME <i>(Please specify relationship to patient.)</i>	SS#	HOME PHONE #	WORK PHONE #
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### If condition is related to Workers Compensation, fill out the information below:

EMPLOYER	DATE OF ACCIDENT
PERSON TO CONTACT FOR VERIFICATION	PHONE NUMBER
GIVE BRIEF DESCRIPTION OF ACCIDENT OR RELATED INJURY:	

OFFICE USE ONLY

Information Reviewed:	Initial	Date	Initial	Date
<u>Only sign on yearly visit</u>				





## **Missed Appointment and Late Cancellation Policy**

When you do not show up for an appointment, it creates an unused appointment slot that could have been used for another patient. To better provide for our patients, we have adopted the following policy:

### **Clinic Appointments**

We require that all patients provide a **48-hour** notice when cancelling or rescheduling a clinic appointment. If you do not provide a 48-hour notice, you will be charged a **\$50.00 fee**. This fee cannot be billed to your insurance company. You will be required to pay the fee prior to scheduling another appointment with our office. If you miss more than three appointments in a 12-month period, you will be discharged from the practice.

**\*\*If you are more than 15 minutes late for your appointment, you may be asked to reschedule your appointment. This will result in a \$50.00 fee for a missed appointment. \*\***

### **Sleep Studies**

We require that all patients provide a 48-hour notice when cancelling or rescheduling a sleep study. If you do not provide a 48-hour notice you will be charged a **\$150.00 fee**. This fee cannot be billed to your insurance company. You will be required to pay the fee prior to scheduling another appointment with our office. If you miss more than two sleep studies in a 12-month period, you will be discharged from the practice.

**\*\*If you are more than 30 minutes late for your sleep study, you may be asked to reschedule. This will result in a \$150.00 fee for a missed appointment. Please call our office ahead of time if you will be running late. \*\***

### **Home Sleep Studies**

We require a **24-hour** notice when cancelling or rescheduling a home sleep study. If you do not provide a 24-hour notice, you will be charged a **\$30.00 fee**. This fee cannot be billed to your insurance company. You will be required to pay the fee prior to scheduling another appointment with our office. If you miss more than two sleep studies in a 12-month period, you will be discharged from the practice.

By signing below, you are acknowledging that you have been notified of our Missed appointment/Late cancellation Policy. If you would like a copy of this policy for your records, please ask the receptionist for a copy.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date



## **Insurance Notification Policy**

It is **YOUR** responsibility to know your insurance coverage including copays and deductibles, or if a prior authorization is needed.

If a prior authorization is needed please let our office know **BEFORE** your sleep study. It is required by insurance that a prior authorization is done prior to the sleep study

Having an authorization approval for a sleep study does not mean that you will not have any out-of-pocket-costs. **\*\*You will need to verify with your insurance what your out of pocket costs will be.**

**You are responsible for any charges your insurance company doesn't cover, including copays and deductibles.**

**Assignment of Benefits:** In consideration of the services provided to me, I hereby assign and transfer to Dr. Gera and Sparrow Eaton Hospital, all medical provider benefits payable and any related rights existing under my insurance policies (but not to exceed the amount of professional charges for services rendered). I authorize and direct my insurance company to pay all such benefits directly to Dr. Gera. **I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company such as deductibles, co-payments, coinsurance and charges for non-covered services.**

**Authorization of Release Claims Information:** I hereby authorize Dr. Gera, its employees and agents, to release and disclose all information that has been and that will be received, recorded, or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize Dr. Gera, its employees and agents to act on my behalf in completing claims.

By signing this form I am stating that I have been made aware of this policy and accept responsibility for any out-of-pocket-costs that my insurance doesn't cover.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date



**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_

I request and authorize Mid-West Center for Sleep Disorders to release healthcare information of the patient named above to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
FAX : \_\_\_\_\_ Email: \_\_\_\_\_

**Please check this box if you would like a copy of your records mailed/emailed to the patient's address listed above for personal use.**

This request and authorization applies to:

All healthcare information. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

Other: \_\_\_\_\_

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Midwest Center for Sleep Disorders. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.
- I understand the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment

**THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_



## Sleep Questionnaire

Please print name on all pages.

<b>Patient's Name:</b>		Gender:	Today's Date:
DOB:	Age:	Race:	Marital Status:
Occupation:		Height:	Referring Dr.:
Current Weight:	Weight 1 year ago:	Recent significant weight loss/gain?:	

What is your main sleep related problem and duration:

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**SLEEP SCHEDULE** (please provide the following information and circle the answer where appropriate)

What time do you go to bed on WEEKDAYS? \_\_\_\_\_ AM or PM WEEKENDS? \_\_\_\_\_ AM or PM

How long does it take you to fall asleep? \_\_\_\_\_

What time do you wake up on WEEKDAYS? \_\_\_\_\_ AM or PM WEEKENDS? \_\_\_\_\_ AM or PM

How many times do you wake up at night? \_\_\_\_\_

Do you **nap**? YES NO

How **often** do you **nap**? \_\_\_\_\_ times per week

How **long** are the **naps**? \_\_\_\_\_ minutes

Do you **awaken refreshed**? YES NO

Are you a **shift worker**? YES NO If yes, what times do you work? \_\_\_\_\_

**SNORING/ BREATHING HISTORY** (please circle appropriate answer)

Do you **currently** use **CPAP/BiPAP**: (If yes, answer question based off of while using your machine) YES NO

⇒ If you do not use CPAP/BiPAP please continue answering the following questions.

Do you **snore**? DON'T KNOW SOMETIMES YES NO

Does your **sleep position** affect your **snoring**? YES NO

Have you awakened **choking** or short of **breath**? YES NO

Has anyone noticed that you **stop breathing** while asleep? YES NO

Do you have morning **headaches**? YES NO

Do you awaken more than twice to **urinate** during the night? YES NO

Do you awaken **refreshed** in the morning? YES NO

Do you awaken with an **acid or sour taste** in your mouth? YES NO

Do you have **difficulty** sleeping on your **back**? YES NO

**Reviewed by:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

**SLEEP HISTORY** (please circle appropriate answer)

- |   |     |    |
|---|-----|----|
| Do you have <b>difficulty falling asleep</b> ?  | YES | NO |
| Do you have <b>difficulty staying asleep</b> ?  | YES | NO |
| Do you <b>wake up too early</b> and cannot get back to sleep  | YES | NO |
| Do you have thoughts <b>racing through</b> you mind that make it difficult to sleep?                    | YES | NO |
| Do you feel <b>excessively sleepy</b> during the day?   | YES | NO |
| Have you fallen <b>asleep unexpectedly</b> ?  | YES | NO |
| Have you ever fallen <b>asleep</b> while <b>driving drowsy</b> ?  | YES | NO |
| Have you ever had a motor <b>vehicular crash</b> due to <b>drowsy driving</b> ?                         | YES | NO |
| Have you experienced <b>“sleep attacks”</b> (a sudden irresistible urge to sleep?)                      | YES | NO |
| Have you experienced <b>sudden muscle weakness</b> in response to emotions?                             | YES | NO |
| Have you experienced <b>an inability to move while falling asleep</b> or waking up?                     | YES | NO |
| Have you experienced <b>dreamlike images</b> or sounds while falling asleep or waking up?               | YES | NO |
| Do you <b>kick or jerk</b> your arms or legs during sleep?  | YES | NO |
| Have you experienced an <b>urge to move</b> your legs accompanied by an <b>uncomfortable</b> sensation? | YES | NO |
| Do you have an urge to move your <b>legs</b> that <b>worsens with rest or inactivity</b> ?              | YES | NO |
| Do you have an urge to move your <b>legs</b> that is <b>relieved by walking or stretching</b> ?         | YES | NO |
| Do you have an urge to move an unpleasant sensation <b>in legs</b> that occurs <b>only at night</b> ?   | YES | NO |
| Do you <b>talk</b> in your sleep  | YES | NO |
| Do you have <b>nightmares</b> ?   | YES | NO |
| Have you ever <b>acted out</b> your <b>dreams</b> ?   | YES | NO |
| Do you <b>grind</b> your teeth?   | YES | NO |

**MEDICAL/SURGICAL HISTORY** (please circle answer and fill in the blank where appropriate)

- |   |     |     |                                |                       |
|---|-----|-----|--------------------------------|-----------------------|
| Have you ever had a sleep study in the past?                            | YES | NO  | When? _____                    | Where? _____          |
| Do you use home CPAP or BIPAP?  | YES | NO  | What pressure setting? _____   | Who prescribed? _____ |
| Do you use home oxygen?   | YES | NO  | What liter/flow setting? _____ |                       |
| Do you have a pacemaker/defibrillator with pacemaker (circle which one) |     | YES | NO                             |                       |
| Have you ever had a tonsillectomy?                                      | YES | NO  |                                |                       |
| Have you ever had sinus or nasal surgery                                | YES | NO  |                                |                       |
| Have you ever broken your nose?   | YES | NO  |                                |                       |
| Have you ever had any type of head injury?                              | YES | NO  |                                |                       |
| Have you had surgery to promote weight loss?                            | YES | NO  | When? _____                    |                       |

Patient Name: \_\_\_\_\_

**Please circle if you have a history of any of the following health problems.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Acid Reflux (heartburn)           | <input type="checkbox"/> Dementia         |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Memory Problems  |
| <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Fibromyalgia                      | <input type="checkbox"/> Claustrophobia   |
| <input type="checkbox"/> Irregular Heart Beat      | <input type="checkbox"/> Sexual dysfunction/loss of libido | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Depression                        |   |
| <input type="checkbox"/> Lung problems/COPD/Asthma | <input type="checkbox"/> Anxiety                           |   |
| <input type="checkbox"/> Stroke/TIA                | <input type="checkbox"/> Seizures                          |   |

Other: \_\_\_\_\_

Surgical History: \_\_\_\_\_

**FAMILY HISTORY** (does any member of your family have the following)

Sleep Apnea?	YES	NO	Relationship _____
Narcolepsy?	YES	NO	Relationship _____
Seizure disorder?	YES	NO	Relationship _____
Depression?	YES	NO	Relationship _____
Hypertension?	YES	NO	Relationship _____
Stroke?	YES	NO	Relationship _____
Heart Disease?	YES	NO	Relationship _____
Psychiatric illness?	YES	NO	Relationship _____
Other Disorder _____			Relationship _____

**MEDICATIONS** (please list Prescribed medications, attach a separate sheet if necessary)

Medication	Dose	# Times/Day	Medication	Dose	# Times/Day

**Medication Allergies (please list)**

\_\_\_\_\_  
 \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Questionnaire updated & reviewed with patient: \_\_\_\_\_ Date: \_\_\_\_\_  
 (OFFICE USE ONLY)

Patient Name: \_\_\_\_\_

**REVIEW OF SYSTEMS**

*(please check where appropriate if you have had any of these symptoms in the last 12 months)*

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent headaches                    | <input type="checkbox"/> Irregular heartbeat                 |
| <input type="checkbox"/> Fainting or passing out               | <input type="checkbox"/> Difficulty swallowing               |
| <input type="checkbox"/> Difficulty understanding instructions | <input type="checkbox"/> Abdominal pain                      |
| <input type="checkbox"/> Difficulty giving instructions        | <input type="checkbox"/> Frequent heartburn                  |
| <input type="checkbox"/> Difficulty following instructions     | <input type="checkbox"/> Frequent constipation               |
| <input type="checkbox"/> Difficulty planning activities/trips  | <input type="checkbox"/> Difficulty urinating/incontinence   |
| <input type="checkbox"/> Sudden loss of vision, strength       | <input type="checkbox"/> Blood in urine                      |
| <input type="checkbox"/> Hearing loss or ringing in ears       | <input type="checkbox"/> Urinating more than 2 times a night |
| <input type="checkbox"/> Nosebleeds                            | <input type="checkbox"/> Pain in bones or joints             |
| <input type="checkbox"/> Cough for more than 2 weeks           | <input type="checkbox"/> Unusual bruising or bleeding        |
| <input type="checkbox"/> Coughing up blood                     | <input type="checkbox"/> Convulsions                         |
| <input type="checkbox"/> Shortness of breath/wheezing          | <input type="checkbox"/> Change in wart, mole or skin growth |
| <input type="checkbox"/> Swelling in feet or ankles            | <input type="checkbox"/> Weight loss of more than 5-10 lbs   |
| <input type="checkbox"/> Chest pain or heaviness               |  |
| <input type="checkbox"/> Other describe) _____                 |  |

**SOCIAL HISTORY**

What is your occupation? \_\_\_\_\_ If retired, when? \_\_\_\_\_

Previous jobs held

\_\_\_\_\_  
\_\_\_\_\_

Marital status \_\_\_\_\_

Do you share a bed with someone?    YES    NO

*(If the answer is "YES" please have your bed partner fill out the Bed Partner/Parent Observation Questionnaire)*

Have you smoked in the past?    YES    NO    Pack per day? \_\_\_\_\_ How long? \_\_\_\_\_

If you quit, when? \_\_\_\_\_

Do you drink beer, wine, or liquor?    YES    NO    How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use recreational drugs?    YES    NO    Do you use Marijuana?    YES    NO

**Signature:** \_\_\_\_\_

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

(Patient/guardian/caretaker)

**Reviewing Technologist:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## EPWORTH SLEEPINESS SCALE

*How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired. Please circle the most appropriate answer using the following scale*

<b>0= Never</b>	<b>1= Occasionally</b>	<b>2= Often</b>	<b>3 = Usually</b>	
How likely are you to doze off or fall asleep while sitting and reading?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while watching television?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while in a theater or meeting?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while traveling as a passenger?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while resting in the afternoon?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while sitting and talking with someone?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while sitting quietly after a meal?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How likely are you to doze off or fall asleep while sitting in a car stopped in traffic?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>

**Total score out of 24:** \_\_\_\_\_ *(please add)*

**Do you feel like your daytime sleepiness can interfere with your daily activities?**    **Yes**    **No**

**Patient Signature:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

## Sleep Log

<b>Patient's Name:</b>	<b>DOB:</b>	<b>Date:</b>
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Bring this completed form with you to the Midwest Center for Sleep Disorders on your scheduled appointment date.

**(MINIMUM OF 2 DAYS IS REQUIRED)**

SPECIFY UNDER APPROPRIATE DAY OF THE WEEK TO THE RIGHT.	Example	MON	TUES	WED	THURS	FRI	SAT	SUN
TODAY I WENT TO BED AND TURNED THE LIGHTS OFF AT _____.	<b>11:15 PM</b>							
AFTER TURNING THE LIGHTS OFF LAST NIGHT, I FELL ASLEEP IN ___ MINUTES.	<b>40</b>							
MY SLEEP LAST NIGHT WAS INTERRUPTED ___ TIMES. (SPECIFY # OF NIGHTTIME AWAKENINGS)	<b>3</b>							
MY SLEEP LAST NIGHT WAS INTERRUPTED FOR ___ MINUTES. (SPECIFY DURATION OF EACH AWAKENING)	<b>10 5 5</b>							
THIS MORNING, I WOKE UP AT _____ AM/PM. (NOTE TIME OF LAST AWAKENING)	<b>6:15 AM</b>							
THIS MORNING, I GOT OUT OF BED AT _____ AM/PM (SPECIFY THE TIME)	<b>6:40 AM</b>							
TOTAL # OF HOURS OF SLEEP LAST NIGHT.	<b>6 HRS</b>							
WHEN I GOT UP THIS MORNING, I FELT _____. (1 = VERY GOOD, 5 = VERY BAD)	<b>2</b>							
OVERALL, MY SLEEP LAST NIGHT WAS _____. (1 = VERY RESTLESS, 5 = VERY SOUND)	<b>3</b>							
TODAY, I NAPPED FOR _____ HRS. (NOTE THE TIMES OF ALL NAPS)	<b>2 HRS</b>							
TODAY, I TOOK ___ MG OF MEDICATION AND/OR ___ OZ OF ALCOHOL AS A SLEEP AID.	<b>ASPIRIN 500 MG</b>							

Patient Name: \_\_\_\_\_

# Mid-West Center for Sleep Disorders

## Bed Partner/Parent Observation Questionnaire

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Check any of the following behaviors that you have observed the patient doing while asleep**

- |   |   |
|---|---|
| <input type="checkbox"/> loud snoring                           | <input type="checkbox"/> bed wetting                        |
| <input type="checkbox"/> light snoring                          | <input type="checkbox"/> sitting up in bed but not awake    |
| <input type="checkbox"/> twitching of legs or feet during sleep | <input type="checkbox"/> head rocking or banging            |
| <input type="checkbox"/> pause in breathing                     | <input type="checkbox"/> kicking with legs during sleep     |
| <input type="checkbox"/> grinding teeth                         | <input type="checkbox"/> getting out of bed but not awake   |
| <input type="checkbox"/> sleep talking                          | <input type="checkbox"/> biting tongue                      |
| <input type="checkbox"/> sleepwalking                           | <input type="checkbox"/> becoming very rigid and/or shaking |

How long have you been aware of the sleep behaviors(s) that you checked above?

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Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

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If you have heard loud snoring, do you remember pauses in the snoring or occasional loud "snorts"?

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\_\_\_\_\_  
Signature of Person Completing this Form

\_\_\_\_\_  
Relationship

Reviewed by: \_\_\_\_\_