PATIENT INFORMATION

Phone: (585) 385-6070
SleepInsights.com

This requested information is very important for the sleep specialist reviewing your sleep symptoms and data. Please respond to all questions. This information is treated with the utmost discretion and will not be used by any party other than Sleep Insights.

DEMOGRAPHICS

Today's Date _______________ Gender ____F ____M Date of Birth_______________________________________

Last Name ______________________________________ First Name____

Address ____

City ____ State ____________________ Zip Code_________________

Home Phone ____________________________________ Work Phone ____

Cell Phone ______________________________________ Email ____

Height ________ ft ________ in Weight ______________ lbs

Marital status: ____ single ____ married ____divorced ____ widowed

First Language: ____ English ____ Spanish ____ Other: ______________________________

REFERRING PROVIDER

Healthcare provider or dentist who referred you to Sleep Insights:

☐ A medical/dental provider did not refer me

Name____ Address ____

Phone ____ ____

Is this a ____ medical provider ____ dentist? ____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired?
Use the following scale to choose the **most appropriate number** for each situation:
0 = would **never** doze **1** = **slight chance** of dozing **2** = **moderate chance** of dozing **3** = **high chance** of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. a movie theater)	0	1	2	3
As a car passenger for more than one hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3

Score Key: Total Score ________________ 1–10 Normal Range 10–12 Borderline 12–24 Abnormal

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Have you ever had a sleep study before? ____ Yes ____ No **If yes, please bring a copy of the study to your appointment if you have it.**

If so, when and where? ____

____

Have you had any prior treatment for sleep apnea? If so, please list:

____

____

SLEEP PROBLEMS **(check all that apply)**

____ Snoring
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Tired/sleepy during the day
____ Morning headache
____ Other: ____

____ Gasping/choking/repeated pauses in breathing while sleeping
____ Unusual behavior(s) during sleep (walking, talking, etc.)
____ Dozing while driving/motor vehicle accidents related to dozing while driving
____ Leg movements before/during sleep

____

Briefly describe your sleep-related problem:

____

____

____

WORK INFORMATION

What is your current employment status?

__ in school __ unemployed __ employed part time __ employed full time __ retired __ disabled

Occupation ____

What is your predominant work schedule? __ Day shift (9am – 5pm) __ Variable schedule
__ Evening shift (3pm – 11pm) __ Night shift (11pm – 7am)

Do you work:

Night shifts:	__ never	__ rarely	__ occasionally	__frequently	__ always
Irregular shifts:	__ never	__ rarely	__ occasionally	__frequently	__ always

SLEEP HABITS

	Work Day	**Non-Work Day**
What time do you get into bed?	____ am pm	____ am pm
What time do you turn off the lights to go to sleep?	____ am pm	____ am pm
What time do you get out of bed to start the day?	____ am pm	____ am pm
How many hours do you actually spend in bed?	____	____
How many hours do you think you actually sleep?	____	____
Do you have a regular bed partner?	____ Yes	____ No

SOCIAL HABITS

When do you usually drink your last cup of caffeinated beverage each day?

Coffee ____ cups per day I drink my last cup no later than ______ am / pm
Tea ____ cups per day I drink my last cup no later than ______ am / pm
Soda ____ cups per day I drink my last can no later than ______ am / pm

How many alcoholic beverages do you have each *day* on average?

Beer ____ 12 oz. serving
Wine ____ 4 oz. serving
Mixed drinks ____ drinks (one drink has 1.5 oz. liquor)

Tobacco use: ____ never used tobacco products ___ cigarettes ___ cigars ___ pipes ___ snuff
History: ____ currently smoke ___ quit smoking year quit: ______
How many packs / cigarettes (please circle) per day did / do you smoke? ____________ Number of years? _______

Drug use? If so, please specify:
____

How many days per week do you exercise 30 minutes or more?
___ 0 days ___ 1–2 days ___ 3–4 days ___ 5–7 days

HEALTH

Have you ever been diagnosed with any of the following? Check all that apply.

- ☐ Allergies/nasal/sinusitis
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign Prostate Hypertrophy
- ☐ Bipolar disorder
- ☐ Brain injury
- ☐ Cancer: ___________________
- ☐ COPD/Emphysema
- ☐ Congestive heart failure
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ GERD (acid reflux)
- ☐ Glaucoma
- ☐ Heart disease (angina, heart attack, stents, CABG)
- ☐ High cholesterol
- ☐ History of addiction
- ☐ Hypertension (high blood pressure)
- ☐ Hyperthyroidism (over-active thyroid)
- ☐ Hypothyroidism (under-active thyroid)
- ☐ Incontinence (loss of bladder control)
- ☐ Insomnia
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Irregular heart beat
- ☐ Kidney disease
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Narcolepsy
- ☐ Parkinson's disease
- ☐ PTSD (Post-traumatic stress disorder)
- ☐ Restless legs syndrome
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Swallowing problems
- ☐ Other: ____________________________

____

Please list all current medications. If attaching a list, it needs to be sent with paperwork.

Medication allergies: ____

Any contact allergies (ex. tape, Band-Aids)? ____

Medication with dosage: ______________________________ Medication with dosage: ______________________________
Medication with dosage: ______________________________ Medication with dosage: ______________________________
Medication with dosage: ______________________________ Medication with dosage: ______________________________
Medication with dosage: ______________________________ Medication with dosage: ______________________________
Medication with dosage: ______________________________ Medication with dosage: ______________________________
Medication with dosage: ______________________________ Medication with dosage: ______________________________

FAMILY HISTORY

Please identify any medical problems that have occurred in your immediate family (blood relatives only). This should include your parents, grandparents, brothers/sisters, and children. If you have an aunt/uncle who had a major medical problem you would like to describe, list it under "other".

	Mother	Father	Grandmother		Grandfather		Brother	Sister	Son/daughter S=son; D=daughter
			Maternal	Paternal	Maternal	Paternal			
Insomnia	___	___	___	___	___	___	___	___	___
Seizure/epilepsy	___	___	___	___	___	___	___	___	___
Parkinson's Disease	___	___	___	___	___	___	___	___	___
Depression	___	___	___	___	___	___	___	___	___
Cancer	___	___	___	___	___	___	___	___	___
Asthma	___	___	___	___	___	___	___	___	___
Anxiety	___	___	___	___	___	___	___	___	___
Dementia	___	___	___	___	___	___	___	___	___
RLS	___	___	___	___	___	___	___	___	___
Hypertension	___	___	___	___	___	___	___	___	___
Heart disease	___	___	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___	___	___
Sleep apnea	___	___	___	___	___	___	___	___	___
Diabetes mellitus	___	___	___	___	___	___	___	___	___

Other:____

____

PHYSICIAN / PHARMACY INFORMATION

Primary Care Provider

Name_______________________________________

Address _____________________________________

____

____

Phone_______________________________________

Pharmacy

Name _______________________________________

Address _____________________________________

____

____

Phone _______________________________________

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HIPAA PATIENT CONSENT FORM

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medication, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health care information (PHI) may be disclosed so that our office can carry out your treatment, obtain payment, and conduct healthcare operations (TPO). **Sleep Insights Medical Associates PLLC** Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available in our office.

Sleep Insights Medical Associates PLLC needs your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below. We will witness your signature.

____

Print Patient Name (and Guardian name if applicable) **Patient Date of Birth**

I give my consent for **Sleep Insights Medical Associates PLLC** to use and disclose my PHI to carry out TPO. With this consent **Sleep Insights Medical Associates PLLC** may mail items or call my home (or other alternate locations) to facilitate treatment, payment, and healthcare operations. They may leave messages concerning healthcare information (such as appointment reminders, payment questions and clinical care) on voicemail, message machines, and with individuals who answer my phones.

___ I do not wish to designate anyone on my behalf with whom to discuss my PHI.

I give my consent to Sleep Insights Medical Associates PLLC to also specifically speak with:

___ spouse: ____

___ relative: ____

___ DOT or employer-directed physician: ____________________________________

___ other: ____

Sleep Insights Medical Associates PLLC may speak with the above-named individuals regarding any of my health information, including, but not limited to clinical information, physician advice and treatment, appointments, and payment information without limitation except for the following:

____

____

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE INFORMATION.

____

Signature of Patient **Date**

PATIENT RESPONSIBILITY AGREEMENT

The doctors and staff of Sleep Insights Medical Associates PLLC appreciate the confidence you've shown in choosing us to provide for your medical care. We're committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES

The patient (or patient's guardian, if a minor) is responsible for payment for his/her treatment and care.

- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Payment is due at the time of the service. We accept cash, checks, debit cards, Visa, MasterCard, American Express and Discover.
- ***ONLY patients with high deductible commercial plans who: 1.) do not have secondary insurance or Medicaid and 2.) haven't met their deductible must pay the following at time of service:***
    - $150 is due at time of service for all consults
    - $50 is due at time of service for all follow-ups
    - $100 at the time of scheduling for all sleep studies

  Any overpayments will be applied to future dates of services or refunded in full.
- Patients may incur and are responsible for the payment of the following additional charges:
    - A $40 fee for all returned checks.
    - A $50 fee will be applied towards all no-show office visits and $100 fee for all no-show sleep studies. While we understand there may be times when you miss an appointment due to emergencies or obligations, Sleep Insights requires a 24-hour notice for all cancelled appointments.
- Patients may be discharged from the practice if two (2) or more appointments are no-showed.

INSURANCE

The following are the patient's responsibility:

- Patients must bring their insurance card to each visit
- Notify our office of any changes to insurance/address/phone numbers
- If there is a change in insurance and we are not notified prior to the change or we do not accept the new insurance, patient may be responsible for payment in full
- Know copays, benefits and coverage and determine if doctor(s) are in-network providers prior to first visit
- Pay for any allowed amounts not covered by insurance

If you do not have insurance benefits, please contact the Billing Department to set up payment arrangements.

PATIENT AND EMPLOYEE SAFETY

We must assure a safe work environment for our employees. Sexual advances and/or verbal or physical assault of any kind upon any of our staff members will result in immediate discharge from our clinic. Discharge in these cases will be at the sole discretion of the treating provider.

CELL PHONE USE CONSENT

Sleep Insights Medical Associates PLLC may contact the patient's cell phone regarding appointments, test results, billing inquiries and any other matter associate with the patient's account. Cell phones may not be used for personal audio or video recording of office visits or in-lab testing.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Sleep Insights Medical Associates PLLC reserves the right to change or amend this statement at any time and at its discretion.

X

Signature of Patient/Responsible Party   Print Name   Date

REQUEST FOR RELEASE OF MEDICAL INFORMATION

☐ **I DECLINE. I DO NOT HAVE ANY MEDICAL RECORDS TO BE SENT TO SLEEP INSIGHTS.**

Please release a copy of my medical records to:

Name of Doctor, Medical Practice or Individual:
Sleep Insights Medical Associates PLLC

Mailing Address of Requested Recipient:

Phone Number of Recipient:

Facsimile Number (Fax) of Recipient:

Patient Signature (or signature of legal guardian):

Printed Name of Patient:

Date of Birth:

PLEASE NOTE THE FOLLOWING:

You can always obtain a copy of your personal medical information for your own records. Once your medical records are in your possession you may copy them and deliver them according to your preferences. Your confidential medical information will only be sent to the place you have indicated on this form; please ensure that the address and/or fax number is accurate. Please allow us ten days to process a routine request. If more urgency is needed, we will attempt to expedite your request.