Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr. Tyler Texas 75701
Phone: 903.787.7533 Fax: 903.787.8825
www.sleeptyler.com

Patient Registration Form

Patient Last Name: ______________________First Name: _________________DOB: ______________Sex: ____

Address: ______________________________________City: __________________State: _____Zip:_________

Home Phone: ____________________Cell Phone: ____________________Work Phone: ___________________

E-mail address (*required*):____________________________________Social Security Number: _______________

Primary Care Physician Name: _________________________________City: ______________State:___________

Referring Physician Name: ____________________________________City: ______________State: ___________

Emergency Contact Name: _____________________________________Date of Birth: ______________________

Emergency Contact Phone number: ________________________Relationship to Patient: ____________________

Ethnicity: Hispanic or Latino / not Hispanic or Latino / prefer not to answer **Language:** English / Spanish /Other

Race: American Indian / Asian / African-American / Caucasian / Hawaiian / Pacific Islander / Refuse to answer

How did you find us? Website/ TV ad/Radio/ Billboard/ dentist / physician referral/ family/ friends

Primary Insurance Information:

Insurance carrier Name: ___________________________ID:________________________Group:______________

Subscriber Name: _______________________________Date of Birth: _______________Relationship:__________

Secondary Insurance Information:

Insurance carrier Name: ___________________________ID:________________________Group:______________

Subscriber Name: _______________________________Date of Birth: _______________Relationship:__________

Medical Consent: I voluntarily consent to medical treatment at Sleep Medicine Institute of Texas

Assignment of benefits: I do hereby assign payment directly to Sleep Medicine Institute of Texas for medical benefits for professional services rendered. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize the release of information as may be necessary for purpose of treatment, payment and operations such as credentialing, peer review, accreditation and compliance with state and federal laws.

Insurance Referrals: I am responsible for getting a referral from my Primary care physician prior to my first visit if my insurance requires a referral to see a specialist. Failure to obtain a referral will case my insurance benefits being paid at a reduced rate or not paid at all. I would then be responsible for the amount not paid by insurance.

Sleep Medicine Institute of Texas has on staff Nurse Practitioners who assists in the delivery of medical care. A Nurse practitioner is a graduate of a certified training program including eight years of RN. BSN and MSN and is licensed by the state board. Under the supervision of the physician, the Nurse Practitioner can diagnose, treat and monitor common acute, chronic conditions and provide maintenance care. "Supervision" does not require the physical presence of the supervising physician but rather overseeing the activities of and accepting responsibility for the medical services provided. I have read the above and hereby consent to the services of nurse practitioner for my health care needs as and when needed. I understand that at any time I can refuse to see the Nurse Practitioner and request to see the physician.

By signing below I am verifying the personal data on this sheet is accurate and indicating I understand the information provided.

Patient Signature:________________________________ **Date**: __________________________

A valid Photo ID and your insurance card(s) are required at check in.

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Financial Policy

Patient Last Name: ______________________First Name: _____________________DOB: ____________

Thank you for choosing Sleep Medicine Institute of Texas, PA as your provider. We are committed to your treatment being successful. Please read the following financial policy and let us know if you have any questions as we would like you to fully understand our policy.

PAYMENTS: Payment is expected at the time of service. We will accept cash, check and all major credit cards. If you do not carry insurance, or if your health insurance has sleep medicine exclusions, or a pre-existing condition clause exclusion, payment in full is expected at the time of office visit and prior to sleep tests, and durable medical equipment purchase.

APPOINTMENTS, NO-SHOW AND CANCELLATION: Appointments are in high demand and it is very important that you keep your appointment time. If you are unable to keep your appointment, please call our office and let us know 24 hours in advance so that we may open that slot for another patient.

NO-SHOW fee: Please be aware that there is a $25.00 no-show fee for missing the office appointment without calling to cancel/reschedule. All sleep tests are subject to $100.00 fee per sleep study appointment if you cancel or reschedule within 48 hours of your sleep study test or do not show up for the Sleep test.

TREATMENT FOR MINOR: As an adult caregiver bringing a minor patient for treatment I am responsible for payment for all services rendered at Sleep Medicine Institute of Texas.

INSURANCE AND PAYMENT FOR OFFICE SERVICES: You are required to provide the office with your health information card and ID card and update us on any changes in your healthcare plans. It is your responsibility to make sure that Dr. R. V. Ghuge and Sleep Medicine Institute of Texas is in your insurance network.

Co-pays, deductible and co-insurance amounts at the time of service: Based on your contract with your health insurance company you will be required to pay the co-pay, co-insurance, deductible and out of pocket expenses. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment due to you. Failure to pay your co-pays, deductible or co-insurance is a violation of your financial responsibility with your insurance company.

RETURNEDCHECKS: You will be required to pay by cash or money order to cover the charges along with the $25 fee.

______I will be charged $25 if my check is returned or non-sufficient funds. I understand that if my bill is turned over for non-payment, I will be charged a collection fee of 25% of the balance due.

MEDICAL RECORDS FEE: According to the Medical Records Release and Charges, Texas Administrative Code. Title 22, Part 9, Chapter 165, Section 65.2, Base medical records copy charges re $25 for the first twenty (20) pages, and $0.50 per page for every copy thereafter. Postage is additional and payment is required in advance. Sleep Medicine Institute of Texas will have 15 business days in which to copy records before making them available for patient to pick up, and these 15days will commence after payment for copying has been received and after patient has signed the form authorizing records 'release. Medical Record does not include billing records.

ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Name of Responsible Party: ________________________________ Relationship to Patient: ___________________

Responsible Party signature: _______________________________ Date: _____________________

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Authorization for Release of Protected Health Information

Patient Last Name: ______________________First Name: _____________________DOB: ____________

I understand that it is the policy of Sleep Medicine Institute of Texas, PA to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company (-ies) for payment of my claim, I would like for the following person/people to have access to my Private Health Information.

Name	Date of Birth	Clinical Information	Financial Information	Restricted Information

ACCESS TO RESTRICTED INFORMATION

If you do not wish to share specific clinical information with any of the persons listed above please specify what clinical information you DO NOT WISH to share:

___Sexually transmitted diseases

___Mental/behavioral health

___Terminal Illness

___Pregnancy

___Other

COMMINICATION: *Please initial here* ___

I hereby give consent to confidential and clinical information being e-mailed to me or left on my voicemail including appointment reminders, referrals, billing and insurance information.

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Sleep Medicine Institute of Texas Notice of Privacy Practices. I understand that Sleep Medicine Institute of Texas has the right to change its Notice of Privacy Practices from time to time and that I may contact Sleep Medicine Institute of Texas at any time to obtain a current copy of the Notice of Privacy Practices.

_________________________________ _________________________

Patient/ Guardian signature Date

_________________________________ _________________________

Staff/ Witness signature Date

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Medications

Patient Last Name: ________________________First Name: _______________________DOB: _____________

Pharmacy Name (local): _________________________Phone: ____________________
Address: _________________________ City: ________________State: ____Zip: _____

Mail Order Pharmacy Name: ____

MEDICATION NAME	STRENGTH	DIRECTIONS

_________________________________ _____________________________

Reviewed by Date

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Epworth Sleepiness Scale (ESS)

Patient Last Name: _______________________ First Name: ______________________ DOB: ____________

This refers to your usual way of life in recent times. Even if you have not 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:

What are the chances of you feeling sleepy in the following situations?

Situations:	**Unlikely to ever feel sleepy 0**	**Mild chance of feeling sleepy 1**	**Moderate chance of feeling sleepy 2**	**High chance of feeling sleepy 3**
Sitting and reading				
Watching TV				
Sitting inactive in public places				
As a passenger in a car for 1 hour without a break				
In a car, while stopped for a few minutes in traffic				
Laying down in the afternoon to rest, if circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch with no alcohol intake				

ESS score: _______

Ghuge Fatigue Score (GFS)

How many hours in the day do you feel tired?

- Less than 2 hrs / 2-4 hrs / 4-6 hrs / 6-8 hrs / more than 8 hrs

What is the intensity of your fatigue? (0 is Minimum to 5 is maximum) 0 1 2 3 4 5

How long have you experienced Fatigue?

- Less than a week / 1 week – 1 month / 1 month – 6 months / 6 months – 1 year / more than 1 year

Does your fatigue interfere with your lifestyle? Yes / No

Does your fatigue interfere with your work? Yes / No

GFS Score: ________________

Reviewed by: ______________________ Date: _________________

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Past Surgical and Sleep disorder History

Patient Last Name: ______________________First Name: _____________________DOB: ___________

Past surgical History:

Type of Surgery	Year	Type of Test	Year
Heart surgery		Colonoscopy	
Brain Surgery		Mammography	
Sinus surgery		Pap smear	
Tonsillectomy		Pneumonia vaccination	
Adenoidectomy		Flu Vaccination	

Other surgeries / tests: ____

Previous Sleep Disorder history:

Have you had a sleep study before? Yes / No

If yes, what year? ____________________ Name of ordering Physician: ____________________________

Type of sleep study: *Please mark all that apply*

Home sleep apnea test / diagnostic sleep study / Titration sleep study / do not know

Are you currently using PAP device? Yes / No Supplemental Oxygen therapy? Yes / No

Dental Appliance for sleep apnea or Bruxism: Yes / No

If yes, since when? ____________________________Name of PAP device provider: ____________________

Type of PAP device: CPAP / BiPAP / BiPAP with ST mode / BiPAP with ST mode with backup rate

Type of mask used: ____

Past experience with PAP device:

____

____

____

____

Reviewed by: ___________________________________ Date: ______________________

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Sleep History and History of Social Habits

Patient Last Name: ______________________First Name: _____________________DOB: ____________

Please circle the appropriate symptoms you have experienced or your spouse /significant other have witnessed:

Snoring:	**Weight:**
Mild / Moderate / Loud / Very Loud Duration of snoring:_____________ Progression: has worsened / has improved Accompanied with apnea: Yes / No	Steady weight : Yes / No Current weight _____________lbs Weight gain of ________lbs in ___yrs Weight loss of _______ lbs in _____yrs
Apnea:	**Insomnia and sleep quality:**
Snort/Gasp/Choke Sleep in separate bedrooms: Yes/No Witnessed apnea/stopped breathing: Yes/No Dry mouth/sore throat in the morning: Yes/No Headaches: Morning/During the day or night: Yes/No Apnea with acid reflux: Yes/No Wake yourself up through the night: Yes / No If yes, how many times do you wake up at night: _________	Bed time:___________Wake-up time:_____________ Time it takes to fall asleep:____________________ Estimated total amount of sleep:________________ Number of awakenings through the night:_________ Wake up with racing hear / gasping / urination / pain/muscle cramps Wake up feeling groggy/sleepy/tired/unrefreshed/ alert/energized Sleep quality is light/sound/variable
Nasal symptoms:	**Dreams and paralysis:**
Nasal congestion or obstruction: Day/Night/All the time Nasal allergies: Yes / No Use nasal or oral decongestants or allergy medications: Yes/No Nasal spray type: Saline/Steroid/Astelin/Astepro/Afrin Nasal drip or drainage: Yes / No	Paralysis with anger/laughter/excitement/during start or end of sleep or during a nap: Yes/No Dreams while awake: Yes/No Vivid dreams / hallucinations during naps or during sleep: Yes/No Dreams associated with anxiety/violence: Yes/No Enactment of dreams: Yes/No
Limbs:	**Headache:**
Restless arms or legs: Yes/No More in the morning/evening/night Relieved with movement	Starts in morning/afternoon/evening/night Headache lasts for _______ hours
Coffee with caffeine: ____________cups per day Do you use caffeine to stay awake during the day? Yes / No Decaffeinated Coffee: ________cups per day Tobacco: _____________per day Cigars/cigarettes: _____________per day	Tea: ________cups per day Caffeinated soda: ____________per day Alcohol: ___________drinks per day Recreational Drugs: Yes / No

Reviewed by: __________________ Date: ______________

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Review of Systems

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Check all that apply:

GENERAL

Anorexia
Excessive daytime sleepiness
Fatigue
Fever
Trouble falling asleep

SKIN

Brittle Nails
Coarse Hair/ coarse skin
Dryness of skin
Hair loss / hair growth
Hives
Lumps
Skin Rash
Skin Color changes

HEAD, EYES, EAR, NOSE, THROAT

Blurred Vision
Decreased Night Vision
Decreased sense of smell /taste
Double Vision
Dry Mucous Membranes
Earache
Ear Discharge
Excessive Tearing
Eye redness
Headache
Head injury
Hearing Loss
Hoarseness
Nasal Congestion
Nose Bleed
Oral ulcers
Puffiness around eyes
Ringing in the ears
Runny nose
Seasonal Allergies
Sleep Apnea
Snoring
Sore Throat
Spinning sensations
Tinnitus (ringing in the ear)
Vertigo
Visual Disturbances
Voice changes

NECK

Neck Mass
Neck pain/stiffness
Neck Swelling

RESPIRATORY

Chronic cough
Difficulty breathing
Decreased exercise tolerance
Difficulty breathing on exertion
Wheezing
Waking up from sleep with:

- Wheezing
- Shortness of breath

CARDIOVASCULAR

Cold cramps
Chest pain
Difficulty breathing lying down
Edema/leg swelling
Elevated Blood pressure
Fainting/black out
Heart stent
Hypertension
Irregular heart beat at night
Heart Murmur
Palpitations

GASTROINTESTINAL

Abdominal pain
Bloating
Difficulty Swallowing
Excessive gas
Heartburn
Indigestion

FEMALE GENITOURINARY

Excessive urination at night
Menstrual irregularities

MALE GENITOURINARY

Change in urinary stream
Difficulty with erection
Excessive urination at night

MUSCULOSKELETAL:

Back pain
Backache
Joint pains
Leg cramps
Leg weakness
Muscle cramps
Muscle pains
Muscle weakness
Myalgia
Swelling of extremities
Swollen glands

NEUROLOGICAL

Decreased memory
Loss of consciousness
Numbness of hands/feet
Seizures
Stoke
Tremors
Weakness

PSYCHIATRIC

Anxiety
Change in sleep pattern
Depression
Disorientation
Early Awakening from sleep
Easily irritated
Fearful
Frequent crying
Hallucinations
Hypersomnia
Impaired cognitive functions
Inability to concentrate
Insomnia
Memory Loss
Mood changes
Panic attacks
Suicidal thoughts
Suicidal planning

ENDORCINE

Excessive thirst
Sexual dysfunction
Thyroid problems

HEMATOLOGY

Anemia
Bleeding disorder

List other:

Reviewed by : ________________
Date: ____________________