



2015-2016
2017-2018
2019-2020
2021-2022
2023-2024

PATIENT DEMOGRAPHICS

TODAY'S DATE: _____ DATE OF BIRTH: _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL INFORMATION: _____

EMERGENCY CONTACT NAME AND PHONE #: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING DOCTOR: _____

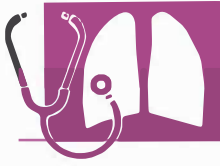
ARE YOU USING OXYGEN OR NEBULIZER? YES OR NO. IF YES, FOR HOW LONG _____

ARE YOU USING CPAP MACHINE? YES OR NO. IF YES FOR HOW LONG _____

NAME OF DURABLE MEDICAL SUPPLY COMPANY FOR MEDICAL SUPPLY NEEDS (DME):

**NAME(S) OF PERSON(S) THAT MAY RETRIEVE ANY MEDICAL INFO AND/OR RECORDS FOR
PATIENT AND THE RELATIONSHIP TO PATIENT:**

SIGNATURE AND DATE: _____



INSURANCE WAIVER/AGREEMENT

PLEASE BE ADVISED:

It is your responsibility as a patient to alert the office staff prior to your scheduled appointment of **ANY** insurance changes; contract ID's, new insurance company, etc.

Please note: It is also your responsibility as patient to check with your insurance company to determine whether a referral/authorization for your office visit or testing being performed in our clinic is indeed required to assure coverage for yourself by your insurance company. This is not the office staff's responsibility to determine for you.

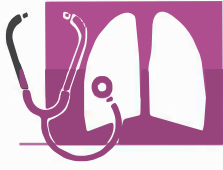
Should a referral/authorization is required and is not obtained or any other charges is not covered by insurance, the charges incurred will be patient's responsibility.

We must emphasize that our relationship is with you and not your insurance carrier. Your insurance is a contract between you, your employer and your insurance carrier. We are not party to that contract. All charges are your responsibility from the date(s) of services rendered.

I have read and understand this policy and agree by signing below:

Patient signature: _____

Date: _____



Lung, Allergy & Sleep MEDICINE CENTER

Consent to the use and disclosure of health information for treatment, payment, or other healthcare operations.

Your health information privacy rights include:

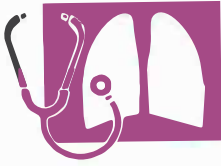
- You can ask to get a copy of your medical record. You may request in writing and pay for the cost of copying and mailing
- You can ask to change/add information ,if you think something is missing or incomplete
- You have the right to request that our practice communicate with you about your health information in a particular manner or location

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans of my future health care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among all health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that the practice will use and disclose my information when required to do so by Federal, State or Local Law. I understand the practice may release my information for workers compensation and similar programs. I understand that the practice reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address provided. I understand that I have the right to object the use of my health information for directory purposes. I have the right to request restrictions for how my information may be used or disclosed. I understand that I may revoke this consent in writing, except to the extent that the practice has already take action in reliance thereon.

Signature of patient or responsible party: _____ Date: _____



2025-2026
Lung, Allergy & Sleep
Medicine Center
1000
1000
1000
1000

ACKNOWLEDGEMENT OF PATIENT OFFICE POLICIES

DEAR PATIENT.

We provide courtesy reminder calls to patients for your appointments. If you are unable to keep appointment, you will have to cancel the day before the appointment or you may be charged a no show fee. If the office is closed, you may leave a message with your answering service. If you do not call to reschedule or cancel your appointment, we will consider it a missed appointment.

Please plan on being here for 1 hour for follow up appointments and 1 ½ hours if you a new patient and if you are unable to wait, you should feel free to reschedule.

Patients please be aware that there will be fees charged to patient account if you are a no show for your appointments, Pulmonary Function Tests and Sleep Study Tests.

Patients please note that Behavioral issues, Financial Delinquency and 2 or more missed appointments will result in discharge from the practice at the discretion of the provider.

I, _____ acknowledge this policy.

Patient Signature _____

Date _____



CONSENT FORM

I authorize Lung Allergy & Sleep Medicine Center to request for medical records on my behalf.

I authorize _____ to request medical records on my behalf.

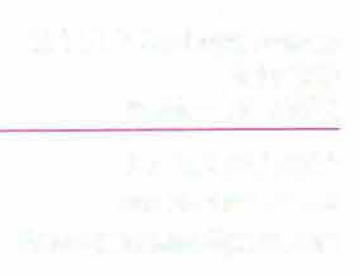
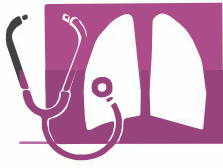
(Patient Name)

(Patient Signature and Date)



OFFICE POLICIES

- **COPAYS:** All copays are due at the time of service, should you choose for your copay to be billed to you instead, it is our obligation to inform you that you will then be charged an additional \$5.00 fee.
- **ALL CANCELLATIONS** without a 24 hour notice will incur a \$50.00 fee for missed appointment. You can call the office at 248-556-5582 or leave a message with the answering service if you can not make it to the appointment.
- **PATIENT CHECK-IN:** You will be asked at every visit for your medical insurance cards and a picture ID so that your insurance company can be billed for charges incurred at your clinic visit.
- **NEW PATIENT:** Be advised to plan at least 1 hour and 30 mts for your first initial visit.
- **MEDICATION REFILL:** In order to obtain refills on your medications prescribed by our pulmonologists, you must be seen at the clinic every 6 months.
- **TEST RESULTS:** Please be advised that the test results are available 24 to 48 hours after the test is performed. If test results are normal, you may not get a telephone call, in this case you may need to call the office to get the results.



SLEEP MEDICINE QUESTIONNAIRE

DATE: _____ **NAME:** _____ **Date of Birth** _____

Occupation(s): Past: _____ Present: _____

1. Please briefly describe your sleep or sleep problems:

2. When did your sleep problem begin?

3. Have you ever been treated for snoring, sleep apnea, sleepiness or insomnia? Yes No

4. Have you ever had a sleep study? Yes No If yes, where, when? _____

5. Do you currently use any of the following: CPAP Machine _____ BIPAP Machine _____ Oxygen _____

If yes, who is your Durable Medical Equipment (DME) Company that you currently use:

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, 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

Watching TV

Sitting inactive in a public place (example a theater or a meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after lunch without alcohol

In a car, while stopped for a few minutes in traffic

Total Score

STOP-BANG Sleep Apnea Questionnaire

STOP

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED , fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE ?	Yes	No

BANG

BMI more than 35kg/m ² ?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No
TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 – 2

Sleep symptoms

1. Do you snore?	Yes	No
2. Does your snoring or kicking prevent somebody from sleeping in the same bed with you?	Yes	No
3. Do you wake up gasping or feeling you cannot breathe?	Yes	No
4. Has your bed partner ever told you that you stop breathing during sleep?	Yes	No
5. Do you have a restless or creepy feeling in your legs that decreased by moving your legs or walking or prevents you from sleeping?	Yes	No
6. Has your bed partner ever noticed leg movements while you were sleeping?	Yes	No
7. Does your bed partner complain that you kick them during the night?	Yes	No
8. Do you toss and turn?	Yes	No
9. Do you get up more than once a night to urinate?	Yes	No
10. Do you grind your teeth at night?	Yes	No
11. Do you ever find yourself somewhere and do not know how you got there?	Yes	No
12. Do you have vivid dreams shortly after falling asleep at night?	Yes	No
13. Do you ever feel that cannot move after lying down or just after you awoken?	Yes	No
14. Do you ever feel sudden weakness in your limbs when laughing emotional?	Yes	No
15. When you waken, are you short of breath or wheezing?	Yes	No
16. Do you waken feeling refreshed?	Yes	No
17. Do you waken with a headache?	Yes	No
18. Do you have a problem with sleepiness while driving?	Yes	No
19. Have you ever had an automobile accident related to sleepiness?	Yes	No
20. Does sleepiness interfere with work or school?	Yes	No
21. Have you ever had accidents at work related to sleepiness?	Yes	No
22. Your approximate Height: _____ Weight: _____		
23. Has your weight changed? Yes No If yes, how much? How long?		
24. Sleep habits	Work days	Weekends
a. What time do you go to bed?	_____	_____
b. What time do you get up?	_____	_____
c. How long does it take you to fall asleep?	_____	_____

d. On average, how many times do you wake up during the night?		
e. How long does it take you to fall back to sleep?		
f. On average, how many hours of actual sleep do you get nightly?		
g. Do you return to bed after arising in am?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h. What time do you go to work or school?		
i. What time do you return home?		
25. How many naps do you take during the day? For how long during the evening? For how long?		
26. How do you sleep away from home e.g. on vacation		
27. Do you have trouble going to sleep?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
28. Do you have frequent awakenings during the night?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
29. Do you awaken during the night and have trouble going back to sleep?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
30. Do you awaken at night with thoughts racing through your mind?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
31. Do you watch T.V. read, eat, etc, in bed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
32. Do you feel frustrated or tense when seeing your bed or bedroom?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
33. Do you fall asleep more easily on the couch than in bed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
34. Do you have difficulty falling asleep or awaken frequently through the night because of pain?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
35. Have you felt depressed recently?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
36. Are you easily awakened by noise or light?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
37. Have you been having any marital conflict lately?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
38. Do you have very much job stress?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
39. Do you find it difficult to get out of bed in the morning?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
40. Is your job or school performance affected by your sleep problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Past Medical History: List any medical conditions: _____

Please list your medications and allergies (along with their reactions): _____

Past Surgical History: Please list, be complete about *date, and type of surgery* _____

Social History: Habits

Do you smoke? Present Past Never

If present smoker: packs/day _____ years _____ If past smoker: packs/day _____ years _____ when quit? _____

How much of the following do you use? 1. Coffee 2. Tea 3. Chocolate 4. Pop 5. Alcohol 6. Recreational Drugs

General

Yes No

Loss of energy

Fever/Chills

Night Sweats

Skin

Rashes

Change in skin color

Unhealed sores

Blood

Unusual bleeding

Easy bruising

Anemia

Enlarges glands

Endocrine

Heat/cold intolerance

Hair growth/loss

Increased thirst

Increased hunger

Throat problems

Difficulty swallowing

Mouth sores

Hoarseness

Lungs/nose

Nose bleeds

Cough

Runny nose

Shortness of breath

Wheezing

Cold

Cardiac

Yes No

Heart problems

Chest pain

Heart murmurs

Heart attacks

Fainting

Gastrointestinal

Abdominal pain

Heartburn

Nausea/vomiting

Diarrhea

Constipation

Blood in stool

Urinary

Burning in urine

Blood in urine

Increased urine

Flank pain

Trouble in start/stop

Neurological

Frequent headaches

Muscle weakness

Trouble talking

Balance problems

Memory changes

Emotion

Mood swings

Crying spells

Depression

Psychiatric treatment