Lung, Allergy & Sleep
MEDICINE CENTER

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: _____

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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: _____

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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:_____

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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 _____

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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)

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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.**

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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 **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes ◉	No ○
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes ○	No ○
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes ○	No ○
Do you have or are you being treated for high blood **P**RESSURE?	Yes ○	No ○

BANG

BMI more than 35kg/m2?	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 gave 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 awaken?	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 ◯ No ◯	Yes ◯ No ◯
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 ◯ No ◯	
28. Do you have frequent awakenings during the night?	Yes ◯ No ◯	
29. Do you awaken during the night and have trouble going back to sleep?	Yes ◯ No ◯	
30. Do you awaken at night with thoughts racing through your mind?	Yes ◯ No ◯	
31. Do you watch T.V. read, eat, etc, in bed?	Yes ◯ No ◯	
32. Do you feel frustrated or tense when seeing your bed or bedroom?	Yes ◯ No ◯	
33. Do you fall asleep more easily on the couch than in bed?	Yes ◯ No ◯	
34. Do you have difficulty falling asleep or awaken frequently through the night because of pain?	Yes ◯ No ◯	
35. Have you felt depressed recently?	Yes ◯ No ◯	
36. Are you easily awakened by noise or light?	Yes ◯ No ◯	
37. Have you been having any marital conflict lately?	Yes ◯ No ◯	
38. Do you have very much job stress?	Yes ◯ No ◯	
39. Do you find it difficult to get out of bed in the morning?	Yes ◯ No ◯	
40. Is your job or school performance affected by your sleep problem?	Yes ◯ No ◯	

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. Alchohol 6. Recreational Drus

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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	○	○
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	○	○
Frequent headaches	○	○
Muscle weakness	○	○
Trouble talking	○	○
Balance problems	○	○
Memory changes	○	○
Emotion		
Mood swings	○	○
Crying spells	○	○
Depression	○	○
Psychiatric treatment	○	○