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New Patient Paperwork

We would like to welcome you as a new patient. Please take the time to complete this form as accurately as possible so that we may most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal regulations concerning the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

Date: _____

Name: _____ DOB: _____ AGE: _____
Last First M.I.

Marital Status: _____Single _____ Married _____Widowed _____Divorced

Address: _____

City/State: _____ Zip Code: _____

Gender: _____M_____F SSN: _____

Race _____ Ethnicity_____

Home Phone: _____Work Phone:_____

Cell Phone: _____ Email Address: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance:_____Phone:_____Subscriber:_____
Contract #:_____ HMO Referral? ☐ Y ☐ N

Responsible Party:_____ Address:_____
_____

Relationship to Patient:_____

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Your Primary Care Provider:_____
Phone:_____
Referring Provider (if different from your PCP), whom may we thank for sending you to our practice?_____

Your preferred pharmacy name:_____
Your preferred pharmacy phone number:_____

Reason for referral/chief concern:_____

How long has this condition been present?_____

Please describe your bedtime routine (e.g.: watch TV, read, etc.):

_____

Do you do any shift work?_____

Have you ever had a previous sleep study: ☐ Y ☐ N
If yes, when and where? _____
What were the results? _____

SLEEP TIMING AND DURATION

	Bedtime (when lights are out)	Amount of time it takes to fall asleep	Wake time	Comments
Weekday				
Weekend				
Vacation				

Do you get unpleasant sensations in your legs when they are resting in the evening? ☐ Y ☐ N

If yes: Do these sensations get worse when your legs are at rest? ☐ Y ☐ N
Do your legs feel better or improve when you move them around? ☐ Y ☐ N
Are these feelings worse in the evening or night than other times of the day? Y ☐ N ☐
How often do you get these feelings?

- ☐ Every night
- ☐ Two or more nights a week
- ☐ Once a week or less (infrequent)

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SLEEP PERIOD: Do you have any of the following while sleeping:

	NO	YES, CURRENT PROBLEM	YES, PAST PROBLEM
Dreams			
Nightmares			
Sleepwalking			
Screaming or crying without subsequent recollection			
Bedwetting			
Frequent movements			
Awakenings			
Snoring			
Choking, gasping, snorting, stop breathing (please circle those that apply)			
Waking to urinate			
Reflux (heartburn)			
Bruxism (grinding your teeth)			
Frequent sweating			
Coughing			
Problems falling asleep			
Problems staying asleep			

POST-SLEEP PERIOD: In the morning, do you:

	Yes	No	Prior History	Comments
Awaken with an alarm				
Wake up refreshed				
Awaken with headaches				If so, how often?
Awaken with dry mouth/sore throat				
Use stimulants to awake (e.g. coffee, tea)				

Do you take daytime naps? ☐ Y ☐ N

If yes: Are the naps usually refreshing? ☐ Y ☐ N For how long do you usually nap? _____

How often do you nap?

- ☐ Approximately once a day or more
- ☐ Between one to a few times a week
- ☐ Less than once a week (infrequent)

Does anything unusual happen to your body when you laugh, tell a joke, get upset or excited? ☐ Y ☐ N

If yes, please describe:_____

Have you ever done anything in your sleep of which you were unaware (but found out about later)?

☐ Y ☐ N If yes, please describe:_____

Have you ever awakened without ability to move your arms and legs (completely paralyzed) for a short time? ☐ Y ☐ N If yes, describe and indicate how many times this has happened:_____

_____

Have you ever felt as though you were "seeing things" (hallucinations) that were not there at either the time of falling asleep or at the time of waking up? ☐ Y ☐ N If yes, please describe:

_____

Do you have problems with memory, concentration or irritability during the daytime? ☐ Y ☐ N

PSYCHIATRIC HISTORY:

History of Depression: ☐ Y ☐ N

If yes, please provide more information:_____

History of Anxiety: ☐ Y ☐ N

If yes, please provide more information:_____

Do you feel that there is a great deal of stress in your life: ☐ Y ☐ N

If yes, please provide more information: _____

History of Drug Abuse: ☐ Y ☐ N

If yes, please provide more information:_____

Other (panic attacks, etc.): Y N

If yes, please provide more information: _____

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Please list all the medications you are currently taking (including non-prescription medicines, vitamins, supplements and birth control pills). You may attach a list if you have one.

Medication name	Dose/How often?	Years taken	Reason for taking

YOUR PAST MEDICAL HISTORY: (Circle illnesses or diseases you have now or have had in the past)

Dementia	Depression	Anemia	Anxiety
COPD	High Blood Pressure	Headaches	Multiple Sclerosis
Aneurysm	Diabetes	Cancer	Fibromyalgia
Stroke or TIA	Heart Disease	Defibrillator	Metal Implants
Liver Disease	Asthma	Kidney Disease	Arthritis
Parkinson's Disease	Nasal allergy	Lupus	GERD
Seizures	Thyroid Disease	Pacemaker	Frequent sinus infections
Drug Abuse	Latex Allergy	Narcolepsy	Restless Leg Syndrome
Sleep Apnea	Panic Attacks	Tonsils	Braces
Wisdom Teeth	Black Outs	Herniated Discs	Ulcer Disease
Grinding Teeth	Thyroid Disorder	Brain Tumor	Cholesterol

ALLERGIES: List any medication allergies you have: _____

_____

_____

FAMILY HISTORY:

Relation	Problem	Onset Age	Died of Age

Do you have a family history of sleep disorders? If so, please list: _____

SOCIAL HISTORY:

1 Do you smoke? ☐Y ☐N If yes, how much? _____
2 Do you smoke E-cigs? ☐Y ☐N If yes, how much? _____
3 Do you drink alcohol? ☐Y ☐N If yes, how much? _____
4 Do you drink caffeine? ☐Y ☐N If yes, how much? _____

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE:

Constitutional	Lack of appetite, feeling ill, fatigue, significant weight change
Eyes	Double vision, glasses, blindness, sensitivity to light, blurred vision, drooping of one or both eyelids
Ear/Nose/Throat	Pain, discharge, hearing changes, dizziness, ringing in ears
Cardiovascular	Chest pain, irregular heart beat or palpitations, fainting spells (syncope), ankle swelling (edema), dizziness with standing, cold hands and/or feet
Respiratory	Shortness of breath, wheezing, cough
Gastrointestinal	Heartburn or reflux, constipation, problems swallowing, difficulty controlling bowel movements
Genitourinary	Urinary urgency, incontinence (loss of bladder control), waking up to urinate at night, decreased sexual interest, problems with erection (for men)
Skin	Rash or color change, itching
Neurological	Difficulty with memory, speech difficulties, tremors, tingling or numbness, head injuries, seizures, loss of consciousness, headaches. Sleep symptoms: restless legs at night, snoring, daytime sleepiness, insomnia
Musculoskeletal	Joint pain, muscle pain, injuries
Endocrine	Goiter, obesity, excessive thirst, excessive urination
Psychiatry	Mood changes, behavior changes, hallucinations, panic attacks, drug abuse
Hematology	Bruising, bleeding, lymph node changes, anemia
Immune/Allergies	Sinus allergy symptoms, frequent infections/illnesses

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Thank you for taking the time to complete the New Patient Paperwork. We look forward to seeing you in our office. Should you have any questions, feel free to give us a call at (804) 269-8291.

Your appointment is scheduled for _____ at ___:___ AM / PM.

The location of your scheduled appointment is:

7650 E. Parham Rd STE 220 Henrico, VA 23294

901 Hioaks Rd. STE A, Richmond, VA 23225

130 Temple Lake Dr. STE 5 Colonial Heights, VA 23834

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Epworth Sleepiness Scale

NAME: _____ DATE: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling simply tired? This refers to your usual way of life in recent times. Although you may not have done some of these things recently, try to calculate how they would have affected you. 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	CIRCLE CHANCE OF DOZING (0-3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place, e.g., theater or meeting	0	1	2	3
As a passenger in a car for an hour, without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
TOTAL SCORE =				

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HIPAA Disclosures to Family Members and Friends

Patient Name: _____

Patient DOB: _____Patient SSN: _____

I hereby agree that disclosures may be made to family and friends listed below as "Included," related to my health and health care services. I also understand that in cases where this form is not accessible or in cases of emergency, the physicians and staff will use their best judgment in complying with my wishes on this matter.

(Circle one)	Relationship	Name
Include – Exclude	Spouse	_____
Include – Exclude	Parent(s)	_____
Include – Exclude	Sibling(s)	_____
Include – Exclude	_____	_____
Include – Exclude	_____	_____
Include – Exclude	_____	_____

Patient/Guardian Signature: _____Date:_____

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Medication Refill Policy

Refills of any medication(s) prescribed by our physicians will be provided during regular business hours; all refill requests require a 48-hour notice.

Medication refills will be given only to those individuals who are actively being treated by our office. You must have been seen within the last 3 to 6 months; otherwise a follow-up visit is required prior to any refills.

Alteration of a prescription or use of a medication against medical advice will not be tolerated. Patients should not expect to be provided any future medications. Your care may be terminated and you may risk prosecution as directed by state and federal laws.

By signing below, you acknowledge that you have read, understand and agree to abide by the above stated MEDICATION REFILL POLICY.

_____ _____

Patient signature Date

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Consent for Treatment/Financial Agreement

I have given permission to **SLEEP CLINICS OF AMERICA** and its staff to perform the following procedures/therapy deemed medically necessary: health history, physical exam, diagnostic procedures, radiology studies, urine drug screens, and treatment for my injury/illness. I understand that the information regarding the results of physical exam, diagnostic procedures and/or nature of my illness may be released to the insurance carrier providing coverage to me. I understand that it is ultimately my responsibility to be aware of the benefits available under my insurance plan, and understand that if I have special requests regarding facilities to be utilized for diagnostics tests/treatment, I should communicate those at the time of my visit(s).

I consent to have my medical information transferred to any physician and/or health care institution that I am referred to by **SLEEP CLINICS OF AMERICA, Inc**. I consent to authorize **SLEEP CLINICS OF AMERICA, Inc.** to request any medical records from other health care providers.

Your signature below forms a binding agreement between **SLEEP CLINICS OF AMERICA, Inc.** (the provider of medical services) and the Patient, who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All copays and deductibles for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform Sleep Clinics of America of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When Sleep Clinics of America receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

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No Show Policy

In the event the patient or responsible party does not call at least 24 hours in advance to cancel or reschedule an appointment, a service fee of $35.00 will be charged, an invoice will be mailed to patient or responsible party, and payment will be due within thirty days.

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 Service Charge. Once notice is received of the returned check, Sleep Clinics of America will send out a letter to notify Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a $35.00 Check Service Charge will be added to the outstanding balance.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Sleep Clinics of America has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

By signing below, you agree to accept medical treatment from our staff and full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

☐ I certify that my answers are true and complete to the best of my knowledge,
I permit Sleep Clinics of America to leave phone messages both oral and electronic at any of the phone numbers listed above.

_____

Patient Name (Please Print)

_____

Patient Signature Date

_____

Responsible Party Name (Please Print)

_____

Responsible Party Signature Date

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Written Acknowledgement Form

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

_____ have been provided a copy of the Medical Practices (please print patient name).

Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

_____

Patient signature Date

_____

Authorized patient representative

_____

Relationship to patient Date