Preferred Sleep Solutions **Date: _____**
Demographic Form

PATIENT INFORMATION

Name of Patient: _____ Male_____ Female _____

Home Address: _____City: _____St: _____Zip:_____

Circle One: Single Married Divorced Separated Widowed

Home Telephone: _____ Cell Phone: _____ Soc. Sec #: _____

Age: _____ Date of Birth: _____

Employment (if applicable): _____ Business Phone: _____

Employer's address: _____ City: _____ St: _____ Zip: _____

EMERGENCY CONTACT

Name:_____ Relationship: _____ Phone: _____

INSURANCE SUBSCRIBER INFORMATION

Name: _____ Date of Birth: _____ Soc. Sec #: _____

Employment: _____ Business Phone: _____

Employer's address: _____ City: _____ St: _____ Zip: _____

If single, name of parent: _____

Address: _____ Phone: _____

INSURANCE INFORMATION (circle one): Please give Card to Receptionist or Technician

Name of Company: Anthem Blue Cross Aetna Humana Medicare Tricare United Health Cigna Blue Cross/Blue Shield

If other, give name: _____ Address: _____

Authorization: I hereby authorize the release of any medical information necessary to process my insurance.

Date: _____ Signed: _____

MEDICARE AUTHORIZATION STATEMENT
I request that payment of authorized Medicare benefits be made to me or on my behalf to Preferred Sleep Solutions for services furnished me by the physicians or the center. I authorize any holder of medical information about me be released to the Health Care Finance Administration and it's agents any information needed to determine these benefits or benefits payable for related services.

Date: _____ Signature: _____

Preferred Sleep Solutions

100 Laguna Road Suite 205
Fullerton, CA. 92835
1305 W Arrow Hwy #102
San Dimas, CA. 91773
Phone: (714) 525-6500
Fax: (714) 489-8140

SLEEP QUESTIONNAIRE

This questionnaire may seem lengthy, but it is important that you fill it out as accurately as possible. Some of the questions may not pertain to your specific complaint, but still answer them as best you can. The questionnaire is a broad based screening tool that is very helpful to us and your physician. It may be helpful to consult family members on some questions. All information contained in this questionnaire is held in strict confidence.

SLEEP QUESTIONNAIRE

I. ***DEMOGRAPHIC DATA***

Name _____ Age _____ Sex _____

Height _____ Weight _____ lbs

II. ***PHYSICIAN INFORMATION***

Name of primary physician:

Dr. _____

Address _____

_____

Telephone # _____

Specialty _____

Name of referring physician:

Dr. _____

Address _____

_____

Telephone # _____

Specialty _____

III. ***SLEEP HISTORY***

Briefly describe the problem you are experiencing with your sleep (why you need to see the sleep physician), and when this problem first began.

_____

_____

_____

_____

_____

PAGE ONE

Have you had problems with excessive daytime sleepiness? YES ____ NO ____

Have you had problems with excessive fatigue during the day? YES ____ NO ____

Do you frequently fall asleep while watching television? YES ____ NO ____

Do you tend to fall asleep during the day when you are quiet and inactive? YES ____ NO ____

Do you feel distracted and unable to concentrate during the day? YES ____ NO ____

Have you had any accidents at work due to sleepiness? YES ____ NO ____

Do you have difficulty staying awake to drive? YES ____ NO ____

Have you had any near traffic accidents due to sleepiness? YES ____ NO ____

Have you had an auto accident in the last 5 years? YES ____ NO ____

Has anyone told you that you snore loudly? YES ____ NO ____

Do you snore in all sleeping positions? YES ____ NO ____

Has your family told you that you stop breathing at night? YES ____ NO ____

Have you ever awakened gasping/choking for breath? YES ____ NO ____

Have you ever awakened at night with coughing or choking? YES ____ NO ____

Do you awaken with a sore throat frequently? YES ____ NO ____

Do you have morning headaches? YES ____ NO ____

Has your weight changed in the last five years? YES ____ NO ____
If yes, how much? Gained _____lbs or Lost _____lbs

Have you ever awakened at night with chest tightness or discomfort? YES ____ NO ____

Have you ever awakened at night with a sour taste in your mouth, or a burning sensation in your chest? YES ____ NO ____

Do you have sudden episodes of sleep during the day? YES ____ NO ____

Have you ever experienced periods in which you feel paralyzed while going to sleep, or waking up? YES ____ NO ____

Have you ever had visual hallucinations or dream-like mental images when falling to sleep? YES ____ NO ____

Have you ever experienced sudden physical weakness during strong emotions?
(such as your mouth dropping open or legs going limp, during laughter or anger) YES ____ NO ____

Did you have childhood sleep problems of any type? YES ____ NO ____

Were you excessively sleepy as a teenager or young adult? YES ____ NO ____

Do you take scheduled naps during the day? YES ____ NO ____

Do you feel better after short naps? YES _____ NO _____

Are you sleepy even on vacation? YES ____ NO ____

Do you kick your legs at night? YES ____ NO ____

Do you have tingly sensations in your legs and you just have to move them? YES ____ NO ____

Do you have difficulty initiating sleep at night? YES ____ NO ____

Do you have frequent awakenings? YES ____ NO ____

Do you usually have restless sleep? YES ____ NO ____

Do you sleep better away from your own bed? YES ____ NO ____
(vacations, visiting family)

Are you sleepy even when you increase your sleep time? YES ____ NO ____

Do you have pain that bothers you at night? YES ____ NO ____

Do you grind your teeth in your sleep? YES ____ NO ____

Have you ever had a severe head trauma? YES ____ NO ____

Do you sleep walk? YES ____ NO ____

Do you wet the bed at night? YES ____ NO ____

Do you talk in your sleep? YES ____ NO ____

Do you have frequent nightmares? YES ____ NO ____

Do you ever wake up screaming at night? YES ____ NO ____

Are you awake at night because of your bed partner? (Noise or movement) YES ____ NO ____

Are you awake at night because some other person needs assistance? (Elderly or infant) YES ____ NO ____

VI. ***CURRENT MEDI CATIONS***

Medication	Dosage	Taken for How long?	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over the counter medications _____

_____

VII. ***SYSTEMS REVIEW***

Have you seen an Ear, Nose, and Throat specialist?	YES ____ NO ____
Have you had sinus x-rays?	YES ____ NO ____
Do you have frequent nose bleeds?	YES ____ NO ____
Do you have nasal allergies?	YES ____ NO ____
Do you have difficulty breathing through your nose at any time?	YES ____ NO ____
Do you have problems with persistent cough?	YES ____ NO ____
Do you have problems with shortness of breath?	YES ____ NO ____
Do you have problems with coughing at night?	YES ____ NO ____
Do you have problems with wheezing?	YES ____ NO ____
Do you have persistent hoarseness or difficulty swallowing?	YES ____ NO ____
Do you have severe heart fluttering, tightness in your chest or chest pain?	YES ____ NO ____
Have you had stomach burning, or other signs of ulcer?	YES ____ NO ____
Do you take antacids?	YES ____ NO ____
Have you had problems with frequent urination or other urinary problems?	YES ____ NO ____

THE EPWORTH SLEEPINESS SCALE

NAME: _____

DATE:_____ AGE_____ MALE _____ or FEMALE_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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.

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 Television	_____
Sitting, inactive in a public place such as a theater or a meeting	_____
As a passenger in a car or an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____
Total score - add all responses	_____

Patient Assignment of Benefit Agreement

I understand that my medical insurance carrier may send the reimbursement payment for the procedures performed by Preferred Sleep Solutions to me (or the subscriber of the insurance plan) directly. By signing this agreement I am assigning all my benefits to Preferred Sleep Solutions and agree to endorse and forward the insurance check upon receipt immediately to Preferred Sleep Solutions.

I understand that I ultimately bear the financial responsibility for the payment of all fees associated with the procedures provided by Preferred Sleep Solutions if the payment is not received by Preferred Sleep Solutions for services they have provided me.

Patient's Name: _____

Patient's Signature: _____

Date: _____

Preferred Sleep Solutions

Patient Consent/ Medical Release/ Receipt of Privacy Practices Form

Patient Consent

I, _____, am requesting Preferred Sleep Solutions and the doctors who practice there to test me for possible sleep disorders. I understand that as a patient, I am required to authorize Preferred Sleep Solutions for such service and am hereby authorizing such tests. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Preferred Sleep Solutions will retain the ownership rights to use these photographs, videotapes, digital, or other images, but I will be allowed access to view them or obtain copies. I understand that those images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. I also acknowledge that I have consulted my physician and understand the nature of the test(s) that I am about to undergo with Preferred Sleep Solutions. By signing this document, I consent to the tests that will be performed on me by the staff of Preferred Sleep Solutions

Patient's Signature: _____

Patient Authorization for Release of Medical Information

I, _____, give Preferred Sleep Solutions my permission to the following family member(s)/ friend(s) information from my medical record in my absence. This release will apply to Preferred Sleep Solutions, any doctors of their staff who provide services to Preferred Sleep Solutions, and my durable medical equipment company (DME) staff used to supply medical equipment to me. Unless otherwise noted this release allows the above entities to leave messages on my answering machine/voice mail, with whomever answers my home phone, and to call me at work.

Patient's Signature: _____

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____ _

EXCEPTIONS: _____

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have received a copy of the Privacy Practices of Preferred Sleep Solutions.

Patients Signature: _____

Witness: _____

Today's Date: _____

(Disclosure Log, office use only)

Date	Description of Disclosure	Description of Patient Health (PHI)	Who Requested	To Whom PHI was sent	Approved Denied	Reasons for Denial, Comments

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Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment- such as order diagnostic tests, other healthcare providers (example: Primary Care Physicians, pharmacies, etc.)
- Payment- such as submitting billing information to your insurance company, disclosures to consumer reporting agencies, (limited to specified identifying information about individual, his or her payment history, and identifying about the covered entity.)
- Health Care Operations- such as quality assurance reviews, coordination of care, and eligibility verification.
- Public Health Activities- such as child abuse or neglect.

In addition to the above, your medical information may be used or disclosed for emergency treatment, when we are required by law to treat you, we attempt to obtain consent, and are to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under circumstances; or we created or received the information in treating an inmate.

You have a right to:

- Request restriction on certain uses and disclosures; however, we are not required to agree to any restriction.
- Receive confidential communications from us, upon written request.
- Inspect and request copies of your medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request or to review out entire policy.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice and obtaining written acknowledgement.
- Abiding by the terms of this notice.
- Providing written notice of any changes to this notice.

Complaints:

You may complain to us if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide a written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks of receipt, and will not retaliate for any allegations you make.

Authorizations:

Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, or other insurance company (apply for life insurance), or a relative. You may revoke any authorization you make at any time except to the extent that it is already relied on.

Patient contact:

We do not need to contact you to provide test results, appointment reminders, and treatment information. If you want to request an alternate or confidential communication, please speak with our office staff to get this taken care of.

To obtain information contact us at: (714) 525-6500 Effective March 01, 2010

Please keep this copy for your records