RenewSleep SOLUTIONS

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr.<br>❑ Mrs. | ❑ Miss<br>❑ Ms. | Marital status (circle one)<br>Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name?<br>❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date:<br>/ / | Age: | Sex:<br>❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.:<br>( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.:<br>( ) |
|---|---|---|

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date:<br>/ / | Address (if different): | Home phone no.:<br>( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.:<br>( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

| Subscriber's name: | Subscriber's S.S. no.: | Birth date:<br>/ / | Group no.: | Policy no.: | Co-payment:<br>$ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.:<br>( ) | Work phone no.:<br>( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

*Patient/Guardian signature* ____________________ *Date* ____________________

**Patient Name:**___________________________________________________________

**Sleep History Questions:** (All questions should be answered **without** using a CPAP maching.)

1. Do you have, or have you had, a CPAP machine? **Y** **N** Use currently? **Y** **N** Setting? ______
2. Has anyone ever witnessed you stop breathing in your sleep? **Y** **N**
3. Do you, or have you ever, woken up choking or gasping? **Y** **N**
4. Have you been told that you snore loud enough to disturb others? **Y** **N**
   Is it worse when you are lying on your back? **Y** **N**
   Is it worse after drinking alcohol before bed? **Y** **N**
5. Do you experience any of the following symptoms:
   a) Daytime sleepiness? **Y** **N**
   b) Difficulties concentrating? ∫**Y** **N**
   c) Impaired thinking? **Y** **N**
   d) Forgetfulness? **Y** **N**
   e) Insomnia? **Y** **N**
   f) Morning headaches? **Y** **N**
6. Have you previously been diagnosed with obstructive sleep apnea? **Y** **N** If yes, when? __________
7. On average, how many minutes does it take you to fall asleep? ________________
8. What time do you generally go to sleep? _______________________
9. Generally, how many hours of sleep do you get? ______________________
10. Do you take any medication to help you sleep? **Y** **N**
    If yes, what medication do you take? ________________________________________________
11. When you wake up, do you still feel tired or unrefreshed? **Y** **N**
12. Do you ever take a nap during the day? **Y** **N**
13. Do you clench/grind your teeth? **Y** **N** In the past? **Y** **N**
14. Do you wake up with a dry mouth? **Y** **N**
15. Do you move around in your sleep (restlessness)? **Y** **N**
16. Do you feel like you need to move your legs to be comfortable at night? **Y** **N**
17. When you wake in the night, do you have difficulty returning to sleep? **Y** **N**
18. Do you remember dreaming at night? **Y** **N**
19. On average, how many times do you get up per night to use the restroom or get a drink of water?_________________________

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## Medical History Questionnaire

Name ________________________________

### Allergens

| | | |
|---|---|---|
| ☐ No known allergens | ☐ Iodine | ☐ Plastic |
| ☐ Antibiotics | ☐ Latex | ☐ Sedatives |
| ☐ Aspirin | ☐ Local anesthetics | ☐ Sleeping Pills |
| ☐ Barbituates | ☐ Metals | ☐ Sulfa drugs |
| ☐ Codeing | ☐ Penicillin | ☐ Other |

If other, list: ________________________________

### Current Medications

| Medication | Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Family History

| | | |
|---|---|---|
| ☐ Cancer | ☐ Stroke | ☐ Father snores |
| ☐ Heart Disease | ☐ Sleep Disorder | ☐ Mother snores |
| ☐ Diabetes | ☐ Obesity | ☐ Father has OSA |
| ☐ High blood pressure | ☐ Thyroid Disorder | ☐ Mother has OSA |

## Social History

Patients Occupation ______________________________ Employer: ___________________________

Tobacco use: Never smoked? **Y N** Current Smoker? **Y N** Quit smoking? **Y N**

\# of packs per day? ______ When? ______________

Other tobacco use: Pipe? **Y N** Cigar? **Y N** Smokeless? **Y N**

Alcohol Use: Do you drink Alcohol? **Y N** If yes, # of drinks per week? __________________

Caffeine use: Do you drink caffeinated drinks? **Y N** # of drinks per day? _______________

Regular exercise? **Y N**

## Confidential Medical History

Recreational Drug Use? Never ☐ Current ☐ Past ☐ HIV/AIDS **Y N**

## Patient Signature

I authorize the relase of a full report of my examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

**I CERTIFY THAT THE MEDICAL HISTORY INFORMATION IS COMPLETE AND ACCURATE.**

Patient Signature: _______________________________________________ Date: _________________

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ________________________________________________, hereby voluntarily authorize the disclosure of information from my health record.

Patient Information:

Name: ____________________________________________ Record Number: ________________

Address: ________________________________________________ DOB: ___________________

Information Requested:

______ Sleep Study Records ________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Purpose of Release:

______ Treatment of obstructive sleep apnea ___________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

The information is to be provided to:

**Name of person/organization/facility:** Renew Sleep Solutions

**Address:** 1050 Texan Trail, Suite 300
Grapevine, TX 76051

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Patient Signature: ___________________________________________ Date: _________________

Printed Name: _____________________________________________________________________

Relationship to Patient ______________________________

**This information is to be released for the purpose stated above and may note be used by the recipient for any other purposes.**

Please make a copy of this for your records

**HIPAA Authorization for Release of Medical Records**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Print Name: ______________________________________________________________

Signature: ______________________________________________________________

Date: ______________________

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient. It could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgment.

We were unable to communicate with the patient.

Other (please provide specific details) ______________________________________________

________________________________________________________________________________

________________________________________________________________________________

Employee Signature: ____________________________________________ Date: ____________