Welcome! Please fill out the information below so that we can better care for you.

Patient Information

Dr. Mr. Mrs. Ms. Jr. Sr. Other _______________

Last Name: ______________________ First Name: ______________________ Middle: _________________

Date of Birth ______/______/______ Female Male

Marital Status Married Single Other _____________

Address: ____

City, State ZIP: ____

E-mail Address: ____

Phone # Home: ______________________ Work: ______________________
Cell: ______________________ Best Number Home Work Cell

Occupation: ______________________________ Employer: ___________________________________

Primary Care Provider: _______________________________ Phone #: ___________________________________
Cardiologist (if applicable): _______________________________ Phone #: ___________________________________
Referring MD (if applicable): _______________________________ Phone #: ___________________________________

Insurance Information

Primary: ____ ID: ____

Secondary: ____ ID: ____

Subscriber Information is the Same as Above (check this box and skip this section)
Other Responsible Party (please fill out the information below if you are not the subscriber)

Last Name: ______________________ First Name: ______________________ Middle: _________________

Date of Birth: ______/______/______ Relationship to Subscriber: ____

Social Security Number: ______-______-______ Female Male

Phone # Home: ______________________ Work: ______________________
Cell: ______________________ Best Number Home Work Cell

Emergency Contact

Emergency Contact Name: ____

Relationship: ___________________________________ Phone #: ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to evaluation and treatment by any provider affiliated with Renew Sleep Solutions. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Renew Sleep Solutions or insurance company to release any information required to process my claims.

Also, I have received/was offered a copy of the company's Privacy Practices. This notice describes how my health information may be used or disclosed and explains my right as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of this notice by requesting it in person or calling the practice.

Patient Name (please print) Signature of Patient or Responsible Party Date

_________________________________ _________________________________ ______/______/______

FOR OFFICE USE

Height: _______ Weight: _______

Pulse: _______ BP: _______

Gender: _______ Neck: _______

Patient Questionnaire

Last Name: ______________________ First Name: ______________________ Date of Birth ______/______/______

Have you ever been diagnosed or treated by a physician for any of the following?

High blood pressure Yes No Stroke Yes No

Heart Disease Yes No Depression Yes No

Diabetes Yes No Sleep Apnea Yes No

Lung Disease (e.g. COPD) Yes No Nasal Oxygen Use Yes No

Insomnia Yes No Restless Leg Syndrome Yes No

Narcolepsy Yes No Morning Headaches Yes No

Are you currently taking: sleeping medication: Yes No pain medication (e.g. Vicodin, Oxycontin): Yes No

If yes, what medications: ____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situation in contrast to just feeling 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 mark the most appropriate box in each situation:

0 – would never doze 1 – slight chance of dozing 2 – moderate chance of dozing 3 – high chance of dozing

Situation:	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place				
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				

How frequently have the following occurred? Use the following scale to mark the most appropriate box for each situation.

Never – 0 Rarely – 0-1 x week Sometimes – 2 x week Frequently – 3-4 x week Almost always – 5-7 x week

Situation	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Almost Always**
On average in the past month how often have you snored or been told you snored?					
Do you wake up choking or gasping?					
Have you been told you stop breathing in your sleep?					
Do you have problems keeping your legs still at night?					

Sleep Questionnaire

Do you snore?

Yes No

If yes, what is the frequency:

1 – 2 nights per week

2 – 4 nights per week

5 + nights per week

Is your snoring:

light

moderate

loud

Is your snoring worse:

sleeping on your back

worse after alcohol

Are you tired during the day? Yes No

Have you noticed a decreased ability to concentrate? Yes No

Do you get sleepy while driving? Yes No

Is your sleep refreshing? Yes No

Do you move a lot while sleeping? Yes No

Do you get sudden weakness in your body during emotional moments? Yes No

Do you hallucinate when going to sleep or waking up? Yes No

Do you remember dreaming at night? Yes No

Do you ever feel paralyzed when you go to sleep or wake up? Yes No

How many caffeinated beverages do you drink a day? ____________________

What time is your last alcoholic beverage? ____________________

Did you ever smoke? Yes No

If you do smoke, what time is your last cigarette? ____________________

Do you exercise regularly? Yes No

On workdays what time do you go to bed? ____________________ Get out of bed? ____________________

On non-workdays what time do you go to bed? _________________ Get out of bed? ____________________

How long does it take you to fall asleep at bedtime? ____________

How many times do you wake at night? _________________________ How long do you stay awake each time you get up? _____________

Do you take naps? Yes No If yes, how long? _________________

In a 24-hour period, how many hours do you spend in bed? ____________________

In a 24-hour period, what is your average amount of sleep? ____________________

Is your bedroom quiet and comfortable? Yes No

Is your bedroom clock lit? Yes No

Do you have a TV, radio, or computer in your bedroom? Yes No

Have you ever been treated for a sleep problem? Yes No If yes, what was it and what was/is the treatment _________________

How long have you had this sleep issue? ____

Please list some of the things you have tried to treat your difficulty sleeping:

____

____

Do you experience any of the following?

Bruxism (grinding teeth) Dry Mouth Morning headaches Waking up and having difficulty returning to sleep

Impaired thinking Forgetfulness Insomnia Urgent need to go to the bathroom during the night

How many times? _________________________

Beck Depression Inventory

This questionnaire consists of 7 groups of statements. Read each group of statements; then pick out the **one statement** that best describes the way you felt in the past **two weeks, including today**. Circle the number beside the statement you picked. If more than one statement applies, circle the highest one.

Sadness

I do not feel sad	0
I feel sad much of the time	1
I feel sad all the time	2
I feel so sad I can't stand it	3

Pessimism

I am not discouraged about my future	0
I feel more discouraged about my future than I used to be	1
I do not expect things to work out for me	2
I feel my future is hopeless and will get worse	3

Past Failure

I do not feel like a failure	0
I have failed more than I should have	1
As I look back, I see a lot of failures	2
I feel like I am a total failure as a person	3

Self-Dislike

I feel the same about myself as ever	0
I have lost confidence in myself	1
I am disappointed in myself	2
I dislike myself	3

Self-Criticism

I don't criticize or blame myself more than usual	0
I am more critical of myself than I used to be	1
I criticize myself for all my faults	2
I blame myself for everything bad that happens	3

Suicidal Ideas

I don't have any thoughts of killing myself	0
I have thought of killing myself but won't do it	1
I would like to kill myself	2
I would kill myself if I had the chance	3

Loss of Interest

I have not lost interest in other people or activities	0
I am less interested in other people or things than before	1
I have lost most of my interest in other people or things	2
It's hard to get interested in anything	3

Current Medical History

Please list all medications you take including over the counter vitamins:

____

____

____

Family History

Please list any serious illness that your mother, father, brothers, or sisters have or had. Please list cause of death if known:

____

____

Cancer Thyroid Disorder Stroke Heart Disease

Diabetes Obesity High blood pressure

Father Snores Mother Snores Father has OSA Mother has OSA

Social History

Do you smoke? Yes No If yes, how long/how many years? ______________________________

How many a day? ______________________________

Quit smoking? Yes No If yes, when? ____________________

Other tobacco use? Pipe Cigar Smokeless

Do you or have you used recreational drugs? Yes No

Are you married, widowed, divorced, or single? ____

Who lives in your home?

____

Do you have any pets?

____

Occupation: ______________________________ Employer: ______________________________

Have you traveled to any tropical or third world countries in the past five years?

____

Do you drink alcohol? Yes No If yes, how often? ______________________________

How many drinks a day? ______________________________

What time is your last beverage? ______________________________

Do you drink caffeinated beverages or take over the counter medication with caffeine as an ingredient? Yes No

If yes, how many caffeinated drinks per day? ____________________

Do you exercise? Regularly Minimally No

Have you tested positive for HIV/AIDS? Yes No

Allergies

No Known Allergies Iodine Plastic Antibiotics Latex Sedatives Aspirin

Local Anesthetics Sleeping Pills Barbiturates Metals Sulfa Drugs Codeine Penicillin

Grass/Pollen/Dust/Trees/Mold Animals Foods: ____

Other: ____

Please list any medical issues you may have had or have that require regular doctors' visits:

____

____

Please list any non-surgical hospitalizations:

____

____

Please list any operations that you have had:

____

____

Review of Symptoms

Please circle those items that have been significant problems in the past few months:

General:	**Gastrointestinal:**
Weight gain greater than 10 lbs. in 5 years Weight loss greater than 10 lbs. in the past 5 years Fatigue Fevers Night sweats	Diarrhea Constipation Nausea Vomiting Difficulty swallowing Choking on food
Head, eyes, ears, nose and throat:	**External:**
Sinus headaches or pressure Stuffy nose Runny nose Nose bleeds Hearing difficulty	Joint pain Joint swelling Difficulty moving arms or legs
Chest:	**Genitourinary:**
Shortness of breath Cough Coughing up blood Wheezing	Difficulty getting or maintaining erections Decreased sexual desire Frequent urinary tract infection Frequent need to Urinate
Cardiovascular:	**Endocrinology:**
Chest pain Irregular heart beat Leg swelling	Difficulty tolerating heat Difficulty tolerating cold
Neurological:	**GYN:**
Headaches Dizziness Poor balance	Irregular period Breast lumps Vaginal bleeding

Any other frequent problems? ____

Describe any other problems or thoughts you have regarding your sleep: ____

____

Describe what you do the hour before sleep: ____

Sleep Studies

Have you previously been diagnosed with Obstructive Sleep Apnea?

If yes, when? ____

If you have had a sleep study please check one of the following:

Home Sleep Study   Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: ____

Sleep Study Date: ____

Are you a CPAP user?   Yes   No

If yes, what are your current CPAP settings? ____

CPAP (Continuous Positive Airway Pressure device) Intolerance

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section:

Mask leaks   Inability to get the mask to fit properly   Discomfort from headgear   Latex allergy

Refuses CPAP   Disturbed or interrupted sleep   Noise disturbing sleep and/or bed partner's sleep

CPAP restricted movements during sleep   An unconscious need to remove the CPAP

CPAP does not seem to be effective   Claustrophobic associations

Does not resolve symptoms

Pressure on the upper lip causing sleep related problems   Other: ____

Other Therapy Attempts

Dieting   BiPAP   Weight Loss   Uvulectomy (but continues to have symptoms)

Surgery (Uvuloplasty)   Surgery (Uvulectomy)   Pillar Procedure   Uvulpolasty (but continues to have symptoms)

Smoking Cessation   Nasal Strips   CPAP   Positional Therapy (side sleeping)

Severity Assessment

Please check the number that corresponds with the severity of the reason you are seeking treatment;

1 being the most severe and 3 being least severe.

	1 - Severe	2 – Moderate/ Mild	3 – No Complaints
CPAP Intolerance	❍	❍	❍
Witnessed cessation of breathing	❍	❍	❍
Nighttime choking spells	❍	❍	❍
Gasping causing waking up	❍	❍	❍
Frequent snoring	❍	❍	❍
Snoring which affects the sleep of others	❍	❍	❍
Excessive daytime sleepiness	❍	❍	❍
Difficulty concentrating	❍	❍	❍
Impaired thinking	❍	❍	❍
Forgetfulness	❍	❍	❍
Insomnia	❍	❍	❍
Morning headaches	❍	❍	❍

Other: ____

Dental Questionnaire

Do you presently have any periodontal disease?	Yes	No
Do you presently have any TMJ disorders?	Yes	No
Do you have any loose teeth?	Yes	No

I authorize the release 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.

Printed Name: ______________________ Signature: ______________________ Date: ______/______/______

Consent for Treatment

I hereby authorize and give permission to the dentist of Renew Sleep and/or any dental auxiliaries to perform an examination and any procedures they deem necessary to treat snoring and/or OSA. These procedures include but are not limited to Cone Beam CT Scan, Fabrication of Impressions, Limited Intra and Extra Oral Examination, and a Bite Registration.

I understand that I will be receiving a limited dental examination to determine only if I am a candidate for an oral dental device. I am not receiving a comprehensive examination that includes but is not limited to a complete set of x-rays, soft and hard tissue evaluation and cavity and gum disease assessments. For a comprehensive examination, I know I must visit my regular dentist. Due to the limited nature of this examination, I understand the dentist is not responsible for diagnosing or treating any conditions or problems related to my dental health.

I understand that dental restorations when fabricated and sealed properly and/or healthy teeth should not be disturbed or dislodged by the fabrication of dental impressions. However, ill-fitting restorations or restorations with underlying problems, as well as compromised teeth, may become loose or dislodged. I acknowledge that no guarantees have been made to me concerning the outcome of the impression procedure and that I will inform the Renew Sleep staff as soon as I become aware of any unwanted outcomes.

I understand that dentistry is not an exact science and the possibility and nature of complications cannot be completely anticipated, therefore, I do not expect any guarantees either expressed or implied.

Printed Name: ______________________ Signature: ______________________ Date: ______/______/______

Financial Agreement

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physicians' staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.

Printed Name: ______________________ Signature: ______________________ Date: ______/______/______

HIPAA Notice of 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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers' compensation, and inmates. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI.

> **You have the right to inspect and copy you PHI**. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a criminal, civil, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
>
> **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
>
> Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.
>
> **You have the right to request to retrieve confidential communications from us by alternative means or at an alternative location**. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
>
> You may have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices for Renew Sleep, Comprehensive Sleep Medicine and Comprehensive Sleep Treatment Associates:

Printed Name: ______________________ Signature: ______________________ Date: ______/______/______

COMPREHENSIVE
SLEEP MEDICINE
Innovative, personalized care to help improve your sleep... *for life.*

PATIENT CONSENT FORM

PATIENT NAME: ____ PATIENT Date of Birth: ____________________

Primary Insurance Company: ______________________________ Policy Number: ___________________________

Secondary Insurance Company: _________________________ Policy Number: ___________________________

Consent to Perform Testing

If diagnostic testing was ordered for me by a medical professional and I do voluntarily consent to and authorize Comprehensive Sleep Medicine to perform the Home Sleep Tests that were ordered. I hereby assign any payments made for services provided to me under my insurance plans to Comprehensive Sleep Medicine (CSMD) for the sleep Tests and to Comprehensive Sleep Treatment Associates (CSTA) for any telemedicine visits and request that those payments be made directly to CSMD/CSTA respectively. I also authorize the release of any information required to process the insurance claims. I understand that I am responsible for any unmet deductibles, Co-Pays and/or Co-Insurance and those will be required to be paid before the testing device is released to me.

1) While the sleep monitoring device is in my possession, I agree to exercise care in its use and handling and return it within the promised time frame in working condition. I understand that failure to return the device on time prevents other scheduled patients from being able to complete their testing: therefore, if I do not return the device to UPS (the brown truck) in the box provided in the prepaid UPS envelope provided by the date agreed upon, I agree to pay the late rate of $25/day until the equipment is returned.
2) I understand that if the device is lost, stolen or damaged while in my possession I may be responsible to pay Comprehensive Sleep Medicine for the repair or the replacement of the device. Please keep the testing device and sensors away from pets, children, water, direct sunlight, and other potential sources of damage.
3) I am receiving the device on ____________(date) and agree to give the device in the envelope back to a UPS representative on ________ (this should be 2 business days from date received, e.g. if received on Tuesday then should take back to UPS on Thursday of same week, if received on Thursday should take back to UPS on Monday of the next week).
4) If I have any questions regarding return of the device I will call 214-390-5653 between 9:00am and 4:00pm CST. If I have any questions about operation of the device I may call the number on the card inside the box 24X7.

If receiving a sleep diagnostic testing device today the serial number is: ___________________

Printed Name: ______________________ Signature: ______________________ Date: ______/______/______