SLEEP MANAGEMENT SERVICES

CLINIC FORM

☐ **Initial Evaluation** ☐**Follow-up Evaluation** ☐**CPAP Compliance**

Appointment Date: _____Location: _____

Patient Name: _____ DOB: _____

Address: _____ City/State: _____

Home Phone: _____ Cell Phone: _____

Name of referring doctor: _____

Primary Care Physician: _____

Height: _____ Weight: _____

Authorization, Consent, Waiver and Disclosure Statement

I authorize my insurance carrier to pay directly to Sleep Partners LLC., Arkansas Neurology and / or Schluterman Neurology, the benefits due me for services rendered. I also agree that the above-named assignees may receive any such payments with my power of attorney and that receipt shall be acknowledgment by me that I have received benefits in the sum specified in such receipt. I acknowledge that my treatment plan may include referral to facilities in which my treating physician has financial interest. I understand that that there are certain services for which my health insurance may not cover and I am responsible for any deductibles, co-insurance, and/or non-covered services. I acknowledge that I will be charged a $25.00 fee for failing to keep a scheduled appointment without any notice. I understand that if I fail to pay my owed balance to Sleep Partners LLC., Arkansas Neurology or Schluterman Neurology, there will be a fee of 25-32% (of balance owed) added to my account to cover costs owed to the collection agency, depending upon whether legal action is required in collection attempts. I certify that all information on this form is true and accurate to the best of my knowledge.

Medicare/Medicaid Certification

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf.

_____ _____

Patient Signature **Date**

1.) What are your primary concerns about your sleep:

1._____

2._____

3._____

2.) How long have you had problems with the above symptoms?

_____ **Weeks** _____ **Months** _____ **Years**

3.) What other medical problems have you had in the past? (Such as high blood pressure, diabetes, heart problems, fibromyalgia, etc.)

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

4.) Please list all surgeries you have had and the date they were performed.

1._____ **3.**_____

2._____ **4.**_____

5.) What medications do you take? (Please list prescription and "over the counter" medications, vitamins, or other supplements you take on a regular basis.)

1._____ **5.**_____

2._____ **6.**_____

3._____ **7.**_____

4._____ **8.**_____

Please list all medications that you are allergic to:

1._____ **3.**_____

2._____ **4.**_____

NAME: _____

6.) List any medical problems that run in your family and the significant medical problems that your mother and father have had.

Father: _____

Mother: _____

Brother: _____

Sister: _____

Other family members: _____

7.) If you smoke, please list how much you smoke and how long you've smoked.

_____ cigarettes/package(s) per day for _____ year(s).

8.) Please place a circle any organ system in which you have had problems and then give a brief description where appropriate. (Examples are given in parentheses)

Allergies/Immunologic (asthma, hay fever):_____

Heart (pain, palpitations):_____

Ears (hearing change, ringing):_____

Nose or Sinuses (drainage):_____

Throat (swallowing problems):_____

Endocrine (hyperglycemia, hair loss):_____

Eyes (Vision change, spots):_____

Stomach (nausea, vomiting):_____

Colon (diarrhea, constipation):_____

Bladder (accidents, urgency):_____

Blood/Lymphatic (anemia, swollen lymph nodes):_____

Skin (dry skin, acne):_____

Muscles (weakness, pain):_____

Joints (pain, swelling):_____

Mood (anxiety, depression):_____

Chest (cough, short of breath):_____

NAME: _____

Epworth Sleepiness Scale:

The Epworth Sleepiness Scale (below) was developed by researchers in Australia and is widely used by sleep professionals around the world to measure sleep deprivation. 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 = No chance 1 = Slight chance 2 = Moderate chance 3 = High chance

SITUATION ***Please circle the appropriate number that relates to the scale given above***	**CHANCE OF DOZING**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e.: meeting, theater)	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 when circumstances permit	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch, without alcohol	0	1	2	3
Driving a car, or while stopped in traffic	0	1	2	3

NAME: _____