Sleep Science Clinics, Texas
Sleep Diagnostics of New Jersey

PATIENT REGISTRATION
AUTHORIZATION, ACKNOWLEDGEMENT AND CONSENT

Welcome to our facility. In order to properly serve you, we will need the following information (Please Print.)
All Information will be strictly confidential.

Patient's Name	Sex ☐ M ☐ F	Birth Date _____/_____/_____	Marital Status ☐ Single ☐ Widowed	☐ Married ☐ Divorced

Patient's Address:	City:	State: Zip:

Home Phone:	Cell Phone:	Patient's Social Security No.

If employed, Name of Employer:	Business Phone:
Employer's Address if applicable:	Occupation:

Person Financially Responsible ☐ Self ☐ Name:	Relationship ☐ Spouse ☐ Other	Resp Party's Birth date _____/_____/_____	Resp's Social Security No. Resp's Phone No.

LIST OF SERVICES TO BE PERFORMED: ☐ SLEEP STUDY ☐ CPAP THERAPY ☐ OAT ☐ MAINTENANCE ☐ Other: _______________	Referring Physician:	
	Person to Contact in Case of Emergency:	
	Relationship to Patient:	Emergency Phone Number:

Primary Insurance (ID Card to be photocopied):	Secondary Insurance (ID Card to be photocopied):

Lifetime Assignments of Benefits/Information Release/Authorization to Treat/Acknowledgement/Consent

I authorize payment of medical benefits to the FACILITY (Provider). for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any medical treatments or procedures.

Further, I have received copies and read the facility's Financial and Payment Policy and Notice of Privacy Practices.

____ _______________________________

Patient, Parent or Guardian Signature (If child is under 18 years old) Date

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Name ____ Height _________ Weight _________

Age __________ Male/Female __________ Tel/Mobile# _______________________________________

Physician Name: ____

Physician Tel: _______________________________ City/State: _________________

Epworth Sleepiness Scale

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

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading-	_____
Watching TV-	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting)-	_____
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 a lunch without alcohol-	_____
In a car, while stopped for a few minutes in the traffic-	_____
TOTAL	_____

00 - 09: Normal Range
10 and over: High Risk of Apnea

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PAYMENT AUTHORIZATION

Date: _____________

Insurance(s):

____

Subject: Patient Name: ________________________________

Member ID: ________________________________

DOB: ________________________________

To Whom It May Concern:

I, ______________________________, authorize payment of medical service(s) to the provider, ________________ for all occasions on which they provide me with covered medical services, including but not limited to PSGs, MSLTs, CPAP Titrations, CPAPs/Bi-Levels, equipment rentals, leases & purchases and other diagnostic testing. This authorization is durable and may only be revoked by an express written request signed by myself. Kindly honor this request to expedite matters for all involved.

Thank you.

Effective Date of Authorization: ______________ _______________________
(Signature)

____
(Print Name)

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Patient Name: ____ DOB:___________________

I hereby acknowledge that I have read and understand this form and any questions I had were answered to my satisfaction. I hereby agree and accept the terms on this form by affixing my initials.

1. **Medical Treatment**
   I do hereby consent to be tested at ____________{PROVIDER} and permit my physician, his/her technician to perform any service or routine diagnostic procedure which the physician deem necessary. I acknowledge that no guarantees have been made as to the result of the tests or examinations in the sleep lab. I also understand that it is possible that this procedure may result in mild and temporary skin irritation. In very rare circumstances skin discoloration can occur.

2. **Release of Information**
   I hereby authorize _______________{PROVIDER] to release part or all of my medical records to other Medical professions, and/or any insurance company, governmental agency managed care organization, or any other entity or person who may be required to pay all or part of the costs of my treatment and/or outpatient care.

3. **Authorize to Video Tape**
   I authorize ___________{PROVIDER} to videotape me during my sleep diagnostic study to facilitate an accurate diagnosis as to the type and severity of any sleep disorder and that all such tapes will be held in the strictest confidence and shared only with medical professionals responsible for my medical care. I understand that I will receive no compensation, whatsoever from any party for permitting such filming.

4. **Assignment of Benefits and Financial Policy**
   Insurance plans with co-insurance/co-pay are the responsibility of the patient and is collected before every treatment is performed.

5. **Personal Valuables**
   I understand that ___________________ {PROVIDER} its trustees, officers, employees are not responsible for loss of, or damage to, property that is kept by me in the sleep lab. I am fully responsible for all articles, jewelry, dentures, eyeglasses, etc. and clothing that I retain in my possession (in the room) and for any other articles that may be brought to me while I am a patient in the Sleep Diagnostics of NJ, Inc. clinic

6. **Privacy Practices**
   I acknowledge receipt of Notice of Privacy Practices.

Patient's Signature ___________________________ **Date** __________________

____
(Print)

Witness ___________________________ **Date** __________________

____
(Print)

Sleep Science Clinics, Texas
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Date of Service: ___________________

PatientName____

Date of Birth:_______________

New Patient

1. Describe your sleep problem: ____

____

2. When did your sleep problem begin: __________________(month/year)

3. Current Medications: (attach a list if you have)

Medication	Dose/Frequency	Last Taken
___________________	________________	______________
___________________	________________	______________
___________________	________________	______________

4. Have you ever had a sleep study performed? ______Yes ______No

If 'Yes', where and what were the results? _________________________________

____

____

5. My occupation is:_______________________________________

My job requires shift ____Yes ____ No My work hours are: ________

6. I have actually fallen asleep while driving a car. Yes ____ No____

If yes, how often? _________ times.

Please consult your bed partner when answering the following questions.

7. I snore ___Nightly ____ Weekly ____ Rarely ____ Never

8. I snore in all sleep positions: ______ Yes____ No

9. My snoring has been described as _______ Mild__________ Moderate______ Loud

10. I stop breathing at night: ____ Yes ____No

11. Please complete the following information for all physicians/healthcare providers you have seen within the past 5 years starting with your primary physician.

12. Indicate whether you have ever had any of the following and if so, please describe:

Abnormal swelling in legs or feet	☐ Yes	☐ No
Pain in calves when you walk	☐ Yes	☐ No
Awakening at night short of Breath	☐ Yes	☐ No
Arthritis and Rheumatism	☐ Yes	☐ No
AID or HIV	☐ Yes	☐ No
Blackouts or loss of consciousness	☐ Yes	☐ No
Cardiac Arrhythmias	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hiatal hernia or reflux esophagitis	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Heart attach	☐ Yes	☐ No
High/Low blood sugar	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Pain, Stiffness or swelling in back, muscles	☐ Yes	☐ No
Problems falling asleep, staying asleep	☐ Yes	☐ No
Rapid or irregular heart beats	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Significant Headaches	☐ Yes	☐ No
Skin rash	☐ Yes	☐ No
Daytime Sleepiness	☐ Yes	☐ No
Sleep Apnea, Snoring	☐ Yes	☐ No
Weight loss or gain of more than 100 lbs.	☐ Yes	☐ No

Describe: ____

____

Patient Name: ______________________ Date of Birth: ______________

Date of Service: ____________________

Pre-Sleep Questionnaire

1. What time did you get into bed last night? ______________________________

2. What time did you get out of bed this morning? ______________________________

3. How much sleep did you get: ______________________________

4. Have you had any of the following in the last 24 hours?

   - ☐ Alcohol
   - ☐ Coffee

5. Have you taken routine medications today? If yes, please list.

____

____

6. Did anything out of the ordinary happen today? If yes, explain.

____

____

7. How tired do you feel right now?

   - ☐ Not at all
   - ☐ Quite a bit

8. How sleepy do you feel right now?

____