Core Sleep Solutions New Patient Intake ***Todays date***

First Name_____ Last Name _____ Middle Initial _____

Address _____City_____ Zip Code_____

Date of Birth_____ Male ( ) Female ( ) Social Security#_____

Ethnicity & Race ( ) White ( ) African American ()Hispanic or Latino ( ) Other

Married Single Divorced

Contact Information: Home_____ Cell_____

Email address _____

Primary Insurance Carrier_____ Group #_____

Subscriber Name_____ Member Id_____

Group Name (Employer) _____ Subscriber DOB_____

Relationship to patient_____

Secondary Insurance carrier_____ Group#_____

Subscriber Name _____ Member Id_____

Group Name (Employer) _____ Subscriber DOB_____

Relationship to patient_____

How did you hear about our office?_____

Purpose of today's visit?

_____

_____

_____

SLEEP CHIEF COMPLAINTS (Please circle all that apply)

Excessive daytime sleepiness
Snoring
Gasping/choking during sleep
Un-refreshed sleep
Difficulty falling asleep
Difficulty staying asleep
Sleepiness while driving
Decreased concentration
Impaired thinking
Not dreaming
Insomnia

Do you have any of the following? (Please circle all that apply)

Eye pain
Facial pain
Headaches/migraines
Jaw pain LEFT OR RIGHT
Jaw clicking/locking
Ear pain LEFT OR RIGHT
Ringing in the ears

How many hours per night do you typically sleep?_____
Have you ever had a lab or home sleep study? _____**When?** _____
Have you been diagnosed with Sleep Apnea or any other sleep disorder?_____

Major Medical History: (please circle all that apply)

Asthma
Blood clots
Cancer
COPD
Diabetes
Head injuries
Heart Attack
Heart Disease
Neck injuries
Stroke
Other_____

Hospitalizations/Surgeries (please list)_____
_____
_____
_____

Current Medications_____
_____
_____

Symptoms checklist (please circle all that apply)
Eyes: Contacts_____ Glasses_____ Blurred Vision_____ Eye Pain_____
Ear, Nose, Mouth, Throat: Dry mouth____ Ear pain/ pressure____ Hearing loss____
Nasal congestion____ Neck pain____Oral pain____ Sore throat____ Tinnitus____
Trouble swallowing____
Respiratory: Shortness of breath Gasping for air Wheezing Snoring
Cardiovascular: Chest pain/pressure at rest____ Chest pain/pressure with exertion____
Cold hands/feet____ Palpitations____ Fainting____ Hypertension____ Heart Disease____
Musculoskeletal: Joint pain___ Joint stiffness___ Muscle weakness___Sprain___
Myalgia (Muscle pain)___ Arthritis___
Neurological: Dizziness___Headache___Numbness___ Speech Disturbance___ Tingling___ Parkinson's___
Alzheimer's Disease___
Psychiatric: Anxious / nervous____ Depressed____

Family History:
Cancer____ Thyroid Problems____ Depression____ Obesity____
Diabetes____ Father Snores____ Mother Snores____ Heart disease____
High Blood Pressure____ Father Has sleep apnea____ Mother has sleep apnea____
Other sleep disorder_____

Do you currently smoke?_____ How much? _____Are you a previous smoker?_____
Alcohol____ beer __wine_____ other____how often_____
Caffeine use_____

Dental History

Last dental exam/cleaning _____Last dental x-rays _____
Are you scheduled for any dental work in the near future? _____
If yes, what kind of work is being performed? _____

Primary Care Doctor

NAME_____PHONE_____FAX_____
ADDRESS_____

Pulmonologist/ENT/Cardiologist/Neurologist (if any)

NAME_____PHONE _____FAX_____
ADDRESS_____

NAME_____PHONE_____FAX_____
ADDRESS_____

Authorization to Release and Request Information

Patient Name: _____DOB:_____

(Initial each item requested)

_____Sleep Study _____Chart Notes relating to Sleep Apnea

_____ Ct or X-ray results _____ Chart Notes relating to CPAP Intolerance

_____ Other _____

Name and address where we may obtain/send your records (Doctor/Hospital or Sleep Lab)_____

_____

_____

Please indicate if you would like your records released to you as the patient. Initial here _____

I authorize Core Sleep Solutions to receive/send my medical documentation information to those listed above.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Core Sleep Solution's treatment of me.

I understand that I may inspect or request copies of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). I understand that I may be charged for review and copying of records.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby knowingly and voluntarily authorize Core Sleep Solutions to use or disclose my health information in the manner described above. I understand that records from other providers or hospitals contained within my chart must be obtained from that provider or hospital.

Designation of Relatives, Close Friends and Other Care Givers

I give permission to share appointment, billing or medical information with the person(s) named below:

NAME AND RELATIONSHIP:

_____

_____

Do we have your permission to:

Leave appointment, billing or medical information on your answering machine/ voice mail/ e-mail?

Y_____ N_____

Patient Signature_____Date_____ __

Parent/ Legal Guardian Signature_____Date_____

Financial Policy

Payment is due at the time of service unless arrangements have been made prior to the start of treatment. We accept Cash, Check, Debit / Credit Cards: MasterCard, Visa, Discover and American Express.

Insurance balances are ultimately the patient's obligation. We will file primary and secondary medical claims as a courtesy. Some of your treatment may not be covered by your insurance carrier. The cost for such charges as copays/coinsurance/deductible will be your patient responsibility.

Patient balances that are neglected may be forced to an outside collections agency for collection. In this event, it is agreed that the patient will be responsible for interest charges and/or collection fees up to 35% of the principal balance. There are additional fees for returned checks as NSF (Non-sufficient funds)

Core Sleep Solutions staff will **estimate the cost** of your out of pocket expenses to the best of our ability with the insurance coverage information quoted by your insurance plan.

We ask that you kindly give 24 hours' notice if you will not be able to keep your appointment. We reserve the right to charge for excessive last minute cancellations and no-shows.

_____ _____

Signature of Patient Printed Name

_____ _____

Date Staff Initials

NOTICE OF HIPPA PRIVACY PRACTICES ACKNOWLEDGEMENT AND DESIGNATIONS

PATIENT CONSENT FORM

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:

1. Plan, conduct and direct your treatment and follow-up among multiple health care providers involved in your treatment.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and Physician certification.

You have the right to review NOTICE OF PRIVACY PRACTICES prior to signing this consent. This organization has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at any time to obtain a copy of the Notice of Privacy Practices.

You may revoke this consent in writing at any time.

Name of Patient (Please print) _____

Signature of Patient / Parent/Guardian_____Date_____

Relationship_____