



Patient Information

Last Name: _____ **First Name:** _____ **Middle initial:** _____

Address: _____

City: _____ State: _____ Zip: _____

Phone-home: _____ Work: _____ Cell: _____

Sex: _____ Marital Status: _____ S.S.N.: _____

Employer: _____ DOB: _____ Age: _____

Race: American Indian / Alaskan Native Asian Black / African American

Native Hawaiian / Pacific Islander White Refuse to Report

Ethnicity: Hispanic / Latin Non Hispanic / Latin Refuse to Report

Preferred Language: _____

Referring Physician _____ Referring Physician Phone _____

Primary Care Physician: _____ Primary Care Phone: _____

Spouse or Parent (if minor) _____ Relationship _____

Contact telephone number _____ Email address _____

Preferred Pharmacy Name _____ Location _____

Employer Information

Name of Patient's Employer _____ Telephone (____) ____ - ____

Emergency Contact

Last Name _____ First Name _____ Relationship to patient _____

Emergency Contact's Telephone Numbers:

Home (____) ____ - ____ Work (____) ____ - ____ Cell (____) ____ - ____

May we release Protected Health Information to your Emergency Contact? Yes No _____ Initial

Insurance Information: [] Self Pay (No Insurance)

Insurance Company (Primary) _____ Subscriber ID: _____

Group Number: _____ Relation to Insured: _____

Subscriber Name: _____ DOB: _____ S.S.N. _____

Insurance Company (Secondary) _____ Subscriber ID: _____

Group Number: _____ Relation to Insured: _____

Subscriber Name: _____ DOB: _____ S.S.N. _____

I am responsible for providing up to date and accurate insurance information to Capitol Sleep Medicine, LLC. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) or under the terms of any other insurance carriers is correct. If your insurance changes I will notify Capitol Sleep Medicine within 10 days of this change. I understand that failure to do so may result in me being billed for any outstanding balances.

I hereby authorize Capitol Sleep Medicine, LLC and / or any of its representatives to submit claims to my insurance carrier or its intermediary for services rendered to me and authorize payment be made directly to Capitol Sleep Medicine, LLC. I hereby authorize release of any information necessary to process medical claims. I authorize release of medical information necessary for continuity of care to Home Medical Equipment companies as recommended by my medical provider.

I understand that my insurance carrier will assign benefits to Capitol Sleep Medicine, LLC. I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier as well as for any applicable copayments, coinsurance, deductibles, and / or charges for non covered goods and services provided to me or to any of my dependents.

I will pay any and all charges due and owing Capitol Sleep Medicine, LLC in accordance with their regular rates, terms, and policies.

By signing below I certify that I will pay to Capitol Sleep Medicine, LLC any copayments, coinsurance, deductibles, or non covered goods and services. I will immediately pay to Capitol Sleep Medicine, LLC any payments I receive from my insurance for services provided by them to me or my dependents. I will also be responsible for any amounts not paid by my insurance due to my failure to provide Capitol Sleep Medicine, LLC appropriate insurance information for billing.

Patient Signature _____ **Date** _____

MEDICAL HISTORY FORM

CARDIOVASCULAR

- Angina/coronary disease
- Cardiac Rhythm disturbance
- Stroke
- Heart attack
- Heart failure
- High blood pressure

ENDOCRINE

- Diabetes and taking insulin
- Diabetes and not taking insulin
- Hypothyroidism (under active thyroid)
- Hyperthyroidism (overactive thyroid)
- Other

GASTROENTEROLOGY

- Esophagitis/heartburn/hiatus hernia/ulcer
- Other

RESPIRATORY

- Obstructive Sleep Apnea
- Asthma
- Emphysema
- Bronchitis / COPD
- Other

INFECTIOUS DISEASE

- Pneumonia
- Other

MUSCULOSKELETAL

- Restless Legs Syndrome
- Scoliosis/ kyphoscoliosis

NEUROLOGY

- Migraine headaches
- Dementia
- Seizures, convulsions
- Multiple Sclerosis
- Other

PSYCHIATRY

- Insomnia
- Depression
- Bipolar Disorder

EAR, NOSE AND THROAT

- Deviated Nasal Septum
- Sinusitis / Nasal Polyps
- Other

SURGICAL HISTORY

- Tonsillectomy
- Oropharyngeal Surgery
- Nasal Surgery
- Bariatric Surgery
- Other

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Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies:

_____	_____	_____
_____	_____	_____

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Health questionnaire

Any Daytime Sleepiness? _____ If yes Mild? _____ Moderate? _____ Severe? _____

Night Sweats? _____

Any changes in your weight in the last year more than 15 LBS?

Is it weight gain? _____ weight loss? _____ how much? _____

Any frequent headaches?

Tension? _____ Migraine? _____

Vision affected by headache? _____ if yes any Nausea? _____ Vomiting? _____

Sinus problems? _____

Any Shortness of breath? _____

Coughing? _____ Wheezing? _____

Chest Pain? _____

Heart palpitation/ irregular heart beat? _____

Frequent urination more than 3 times a night? _____

Any arthritis/ backaches? _____

Numbness/tingling in arms or legs? _____

Depression? _____

Anxiety? _____

Irritability? _____

Problems with insomnia? _____

Social History

Any history of smoking? Yes or No

Current smoker? Yes or No

How much are you smoking a day or how much did you smoke a day? _____

Any alcohol? Yes or No

How often do you drink alcohol? Often Rare Social

Any caffeine intake? Yes or No

How much caffeine a day? _____

Are you currently working? Yes or No

Are you a commercial driver? Yes or No

Family History:

Anyone with sleep apnea? Yes or No

Narcolepsy Yes or No

Cancer? Yes or No Type: _____

Stroke? Yes or No

Heart attack? Yes or No

High blood pressure? Yes or No

Other: _____

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Diagnostic Tests performed in the past

Directions: Please fill in all that apply as completely as possible. This information may prevent unnecessary duplication of diagnostic studies. If you have not had a particular test, leave the space blank.

Test	Month/year	Where	Results
All-night sleep study	_____		
Multiple Sleep Latency Test (MSLT)	_____		
Maintenance of Wakefulness Test (MWT)	_____		

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, 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 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

Situation	Chance of Dozing			
	never	slight	moderate	high
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive, in a public place, e.g. in a meeting...	0	1	2	3
As a passenger in a car for an hour without a break ...	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic ...	0	1	2	3

Total Score _____

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Financial Policy

Thank you for Capitol Sleep Medicine, LLC the opportunity to participate in your health care. We are committed to providing quality service.

1. It is your responsibility to have provided us with up to date insurance information. In addition to your insurance card we will ask for your photo ID. You will be responsible for any amounts not paid by your insurance because you have not provided appropriate insurance information to Capitol Sleep Medicine, LLC.
2. You must complete and sign any required information sheets and/or payment agreement forms before seeing the doctor or receiving service from our practice.
3. It is your responsibility to understand your insurance benefits, obtaining proper authorization for services, and submit referral claim forms if necessary.
4. Many insurance plans require patients to pay a co-payment, deductible, or co-insurance amount. It is your responsibility to understand any applicable co-payments, co-insurances, and deductibles. Please come to your appointment prepared to pay your co-payment.
5. If you have no insurance or if Capitol Sleep Medicine does not participate in your insurance plan, payment in full is required prior to receiving goods and services.
6. Insurance benefits are the result of the contract with your insurance company. If your insurance plan does not pay our bill within sixty days after billing, or your claim is denied, you will receive a statement from Capitol Sleep Medicine, LLC indicating that the bill is now your responsibility. Patient balances are billed upon receipt of your insurance plan's explanation of benefits (EOB). Your payment is due within ten business days of your receipt of our bill.
7. Capitol Sleep Medicine, LLC requires at least forty eight (48) hours notice for cancelling a sleep study appointment. Failure to provide timely notice of cancellation for a sleep study may result in a cancellation fee of \$150.00.
8. Checks written to Capitol Sleep Medicine that are returned by your bank due to insufficient funds will incur a \$50 penalty.

Other Items:

1. Security is a priority for Capitol Sleep Medicine, LLC. We have a security system for our building. At the Grove City location we have security cameras as well monitoring the parking lots. Nevertheless, it is possible that theft or damage to your personal property may occur while parking on our property. Capitol Sleep Medicine claims no responsibility for loss or damage to personal property while parked in our parking lots. You hereby release Capitol Sleep Medicine LLC from any and all claims from liability from any loss or damage to personal property that occurs on our premises.
2. If you take any medications you should check with your physician as to whether you should take them on the day of your study. If the physician has given you a prescription for a sleep aid, please bring this medication with you. The sleep technicians do not dispense medications to patients. **Please be aware that medications you may take to help you sleep in the sleep lab may cause drowsiness, and in this case it is your responsibility to arrange for a ride home after your study.**

I AGREE TO COMPLY FULLY WITH ALL POLICIES AS DETAILED ABOVE.

Signed _____

Date _____

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HIPAA / ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

By signing the following you are giving Capitol Sleep Medicine LLC permission to use and disclose your protected health information in accordance with the directives listed below:

I _____ on this date _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- * The right to review the notice prior to signing this consent
- * The right to object to the use of my health care information for directory purpose
- * The right to request restrictions as to how my health care information may be used or disclosed in this _____ office to carry out treatment, payment, or health care operations

Signed _____

Date _____