DO SLEEP SOLUTIONS, INC

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Phone: (727) 826-0933 Fax: (727) 350-3487

Patient information

Name: ____ DOB: ___/___/___

Sex: ☐ MALE ☐ FEMALE ☐OTHER ________________

Address: _______________________________ City: ________________ State:____ Zip: ______

Phone: (_____) _________________ Cell: (_____)_________________ Preferred:_____

Email: _________________________ ☐Check box if we may use this cell# for appt reminders text

Preferred Method of Contact: ☐ PHONE ☐EMAIL ☐TEXT

Nationality: ☐African American/Black ☐American Indian/Alaska Native ☐Asian
☐Native Hawaiian/Pacific Islander ☐White

Ethnicity: ☐ Hispanic ☐Non-Hispanic ☐ Declined

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Separated ☐Partnership

Primary language ☐ English ☐ Other ______________________

Who may we thank for referring you: ____
Primary Care Provider: ______________________________ Phone: (____)_______________
Preferred Pharmacy: ___________________________ Cross streets _____________________ Phone # ________________
Smoker: ☐ Yes ☐ No ☐ Prefer not to answer

Employer Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐Unemployed ☐Student
Occupation: ___________________________________ Employer __________________________
Employer Address ______________________________________ Work phone (____) ___________

Emergency Contacts

#1 Name: ____________________________ Relationship _____________ Phone: (____) ______________

#2 Name: ____________________________ Relationship _____________ Phone: (____) ______________

Insurance Information

Primary Insurance Carrier: _______________________ Policy#________________ Group#__________
Policy Holder Name __________________________________ Date of Birth ______________
Policy Holder last 4 SSN ________________ Relationship to Patient ___________________________
Claims Address: _____________________________ City_________________ State__________ Zip______
Eligibility Phone __________________________ Copay Amount ___________________
SecondaryInsurance Carrier: _______________________ Policy#________________ Group#__________
Policy Holder Name __________________________________ Date of Birth ______________
Policy Holder last 4 SSN _______________ _ Relationship to Patient ___________________________
Claims Address: _____________________________ City_________________ State__________ Zip______
Eligibility Phone __________________________

DO SLEEP SOLUTIONS, INC

EPWORTH SLEEPINESS SCALE

Date __________________

Patient's name: _________________________________ Date of birth: __________

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 affect you. Use the following scale to choose the most appropriate number for each.

0 = WOULD **NEVER** DOZE

1 = **SLIGHT** CHANCE OF DOZING

2 = **MODERATE** CHANCE OF DOZING

3 = **HIGH** CHANCE OF DOZING

SITUATION	CHANCE OF DOZING
1. Sitting and Reading	0 1 2 3
2. Watching television	0 1 2 3
3. Sitting inactive in a public place	0 1 2 3
4. As a passenger in a car for an hour without a break	0 1 2 3
5. Lying down to rest in the afternoon when circumstances permit	0 1 2 3
6. Sitting and talking to someone	0 1 2 3
7. Sitting quietly after lunch without alcohol	0 1 2 3
8. In a car, while stopped for a few minutes in traffic	0 1 2 3

TOTAL: ____________/24

DO SLEEP SOLUTIONS, INC

A good sleep is important to your well-being. Since most people spend roughly 1/3 of their lives asleep, it is easy to see how the quality of sleep directly affects the quality of your life. One in 3 Americans has a sleep disorder making sleep/waking hours miserable. Many of these people suffer needlessly because they are unaware that a problem exists. Once detected, most sleep disorders can be corrected. *If you have experienced any of the following symptoms in the last year, check the box YES. When referring to night, assume that this means during your sleep period.*

Patient name: ____ Date of Birth: ___________

Section 1:	**YES**	**NO**
1. I have difficulty falling asleep.		
2. Thoughts race through my mind and this prevents me from sleeping.		
3. I feel afraid to go to sleep.		
4. I wake up during the night and have trouble falling back asleep.		
5. I worry about things and have trouble relaxing.		
6. I wake up earlier in the morning than I would like.		
7. I lie awake for 30 minutes or more before I fall asleep.		
8. I feel sad and depressed.		
Section 2:		
9. I have been told that I snore.		
10. I have been told that I stop breathing sometimes when I sleep.		
11. I have been told my blood pressure is high.		
12. I have been told by friend/family that my personality has changed.		
13. I am gaining weight.		
14. I feel that I sweat more than I should at night.		
15. I have noticed my heart pounding during the night.		
16. I get morning headaches.		
17. I have trouble sleeping when I have a cold.		
18. I wake up suddenly some nights gasping for breath.		
19. I am overweight.		
20. I am losing my sex drive.		
21. I feel sleepy during the day even when I sleep through the night.		
Section 3:		
22. I have a chronic cough.		
23. I have to use antacids (Tums, Alka-Seltzer, etc) at least once a week.		
24. I have morning hoarseness or get sore throats.		
25. I wake up at night coughing or wheezing.		
26. I wake up at night needing to catch my breath or with chest pain.		
Section 4:	**YES**	**NO**
27. I have had trouble concentrating in school/work.		
28. When I am angry or surprised, I feel like I'm going limp.		
29. I have fallen asleep while driving.		
30. I feel like I go around in a daze.		
31. I have experienced vivid dream-like scenes upon falling asleep/waking.		
32. I have fallen asleep during physical effort.		
33. I feel like I am hallucinating when I fall asleep.		

Section 4 continued:	YES	NO
34. I like to cram a full day into every hour to get everything done.		
35. I have fallen asleep when laughing or crying.		
36. No matter how hard I try to stay awake, I fall asleep anyway.		
37. I sometimes feel like I am unable to move waking up or falling asleep.		
Section 5:		
38. Other than when exercising, I will experience muscle tension in my legs.		
39. I have noticed (or others comment that parts of my body jerk.		
40. I have been told that I kick at night.		
41. I experience aching/"crawling" sensations in my legs.		
42. I experience leg pain during the night.		
43. Sometimes I can't keep my legs still at night; I just have to move.		
44. I awaken with sore or achy muscles.		

Questions about your habits:

Weekday: Bedtime ____________ Wake up _____________ Nap ___________

Weekend: Bedtime ____________ Wake up _____________ Nap ___________

Work hours: _______________________ Shift work? YES NO Type of work: __________________

Please provide information for the following procedures:

CHEST XRAY/CT in the last year YES NO If yes, where _______________________________

Pulmonary Function/6 minute walk YES NO If yes, where _______________________________

Sleep studies (home or in lab) YES NO If yes, where _______________________________

Are you currently using CPAP/BIPAP? If yes, bring your compliance card/PAP machine to the office

Do you work with a durable medical equipment (DME) company ___________________

Family medical information ◯ **If unknown** ◯ **Adopted**

Parents **Mother** ______________ **Father** ______________

Siblings **Sisters #** ______________ **Brothers #** __________________

Children **Daughters #** _________________ **Sons #** ____________________

Patient name: ____ Date of Birth: __________

DO SLEEP SOLUTIONS, INC

REQUEST FOR CARE & CONSENT

The undersigned consents to the medical care and treatment, as it may be deemed necessary or advisable in the judgment of my licensed care provider, which may include but are not limited to laboratory, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's licensed care provider. DO SLEEP SOLUTUIONS, INC has the right to refuse to see you if you refuse to sign the consent or if at any time you choose to revoke this consent.

Patient/designee signature ____ **Date** _________________

ASSIGNMENT OF BENEFITS

I request the payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, may be made on my behalf to DO SLEEP SOLUTIONS, INC for any medical services provided to be by the organization (including in person and tele-visits). I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equivalent or services to the organization, the Health Care Financing Administration, my insurance carrier or other insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance company or other entity if requested. The original will be kept on file by the organization. I understand that I am financially responsible to the organization for any charges that are not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received/been offered a copy of the organization's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure aware of my rights.

Patient/designee signature ____ **Date** ________________

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time of rendered services by the patient or the person accompanying the patient. If our office is a participating provider with your health insurance carrier, all non-covered services, co-pays and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plans. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by any insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient/designee signature ____ **Date** ________________

DO SLEEP SOLUTIONS, INC

What is HIPAA?

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information.

I have been offered and received a copy of the HIPAA form by DO Sleep Solutions, Inc. I have been asked to review the information and given opportunity to ask questions if I am unclear about the meaning of the information.

Patient/designee signature ____ **Date** ________________

E-MEDICATION HISTORY DOWNLOAD

The Medication History services allows prescribes and pharmacies to use the Surescripts network to access a patient's Medication History across providers, at the point of care. This service can be used in the course of providing routine care, as well as during emergencies (like natural disasters). In both cases, Medication History enables healthcare providers to make a more informed clinical decision. To provide this service, Surescripts securely connects to a patient's medication history data stored in the database of community pharmacies and pharmacy benefit managers. Surescripts requires patient consent as part of the process a prescriber must go through each time they electronically access a patient's medication history. If a request for medication history is sent to Surescripts and the patient consent flag is not set, Surescripts rejects the request.

I hereby provide DO SLEEP SOLUTIONS, INC, the ability to download my complete Medication History from the nationwide database of pharmacies.

Patient/designee signature ____ **Date** ________________

CANCELLATION/NO SHOW POLICY

The cancellation/no show policy is a courtesy to the office and patients. Cancelling or rescheduling an appointment must be done a minimum of 24-hours prior to your appointment date whenever possible. Per office policy missed appointments and rescheduled within this 24-hour period are subject to a $50 fee. DO SLEEP SOLUTIONS, INC reserves the right to decline any future appointments after two occurrences and if no payment arrangement has been made or be discharged from the practice. **NOTICE:** Please be courteous to the office and arrive on time for your appointments as those that are more than 10 minutes late may be subject to rescheduling at the discretion of practice manager.

I have read and understand the cancellation/no show policy for DO SLEEP SOLUTIONS, INC.

Patient/designee signature ____ **Date** ________________

DO SLEEP SOLUTIONS, INC
MICHELLE ZETOONY, DO, FCCP, FACOI
PATIENT MEDICAL HISTORY

Date: ____/____/_____

Patient name: ____ **Gender** M F U **DOB**: _________________

Height _________ **Weight** _____________

Past Medical History (Please answer all questions to the best of your ability):

Do you now or have you had:

	YES	NO		YES	NO
Tuberculosis (TB)			Thyroid Disease		
Cancer (type)			Stomach Disease (ulcers, reflux)		
High blood pressure			Intestinal Disease		
Diabetes (sugar high/low)			Liver Disease		
Heart attack			Seizures		
Kidney Disease			Urinary issues		
Lung Disease			Other:		

Please explain all of the "YES" answers: ____

____

Habits: Do you now or have ever used:

1) Tobacco (cigarettes, chew, pipes, vape, etc) YES NO
If yes, how long? _______years. Quit? YES NO

2) Alcohol (beer, liquor, wine, etc) YES NO
If yes, How long? ______ years. YES NO

3) Caffeine (soda, coffee, tea, energy drinks, etc0 YES NO
How many per day? _____

4) Illicit drugs (injected, inhaled, etc) YES NO
If yes, quit? YES NO Total years ________

Medication Allergies/Intolerance (Reaction)

1) →
2) →
3) →
4) →
5) →

Food and Environmental Allergies (Reaction)

1) →
2) →
3) →
4) →
5) →

Prior Surgeries (Dates if known):

1)
2)
3)
4)
5)

Medications Taken Routinely (w/ doses)

1)
2)
3)
4)
5)
6)
7)
8)
9)
10)
11)
12)
13)

DO SLEEP SOLUTIONS, INC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DO SLEEP SOLUTIONS requests that patients obtain all records relevant to their appointment with the office. This information may be brought with you or faxed to the office prior to your appointment. It is the patient's responsibility to provide these records. FAILURE TO PROVIDE THESE RECORDS MAY NECESSITATE RESCHEDULING THIS APPOINTMENT.

Instructions: Please complete and sign this authorization and forward it to the appropriate facility to obtain records. If you complete the record request we would be happy to fax this for your at your request. Thank you!

TO: ___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

REQUESTED RECORDS:
- ◯ All Sleep Studies and office notes prior
- ◯ All pulmonary function tests/spirometry/6 minute walk tests
- ◯ All chest imaging (chest xray, CT chest, ultrasound, etc)
- ◯ All pertinent clinical notes
- ◯ All laboratory studies
- ◯ Other ____

I hereby authorize you to release my medical records. I understand that my records may contain information about drug or alcohol abuse, communicable diseases, HIV testing or results of psychiatric or psychological conditions.

Released records may be sent to **DO SLEEP SOLUTIONS, INC**

FAX preferred **10707 66th Street N, Suite B, Pinellas Park, FL 33782**

PHONE: 727-826-0933 FAX: 727-350-3487

If there are NO RECORDS, please indicate here: ___________________________________

Patient Name: ____ Date: __________________

Date of Birth: _____________________ Previous name(s) if applicable: ____________________

Patient signature (over age 18) ____

Personal Representative name & signature (if under 18) _________________________________