Patient Demographics

☐ Baylor Medical Plaza - Wadley Tower
3600 Gaston Ave #1053, LB 102
Dallas, TX 75246
214.827.0330 Fax: 214.827.2860

☐ Plano
3604 N Preston Rd #300
Plano, TX 75093
972.612.1600 Fax: 972.612.1601

1.800.SNORING · 1-800.766.7464 WWW.SLEEPCENTERSOFTEXAS.COM

All information will be confidential. In order to serve you properly, we request the following information:

Patient name (last, first): ____ Male ___ Female ___

How did you hear about us? (Circle one) Physician Referred by: _________________________

Website/Internet Yellow Pages Television/Radio Magazine/Newspaper

Insurance Co. Patient/Friend Other: ____________________

DOB: ______________ SSN: __________________________

Email address: ______________________________________

Home phone: (____)____________________ Work phone: (____)____________________

Cell phone: (____)____________________ Alt phone: (____)____________________

Address: ____

City: ____________________________ State: _________ Zip:____________

Emergency contact name (last, first): ____

EC Phone: (____)____________________ EC Relationship: _____________________

- I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize the release to my DME provider or referring/consulting/primary care physician of any information that may be needed.
- I authorize SCT to obtain a photograph for my medical records.
- I hereby authorize all payments of insurance benefits to go directly to SCT or practitioner even if it is made payable to me. I understand that any allowed charges not fully paid by my insurance will be my responsibility and will be billed accordingly.
- I authorize the sleep center staff to perform necessary service I may need.
- I acknowledge that I have been given the option to read the SCT “Notice of Privacy Practices”.

X _______________________________________ ____________________
Patient Signature Date
X _______________________________________ ____________________
Witness Signature Date

1.800.SNORING · 1-800.766.7464
WWW.SLEEPCENTERSOFTEXAS.COM

□ Baylor
□ Plano

RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO:

□ SLEEP CENTERS OF TEXAS
3600 GASTON AVE., #1053, LB 102
DALLAS, TX 75246
Fax# 214-827-2860

□ SLEEP CENTERS OF TEXAS
3604 N. PRESTON RD. # 300
PLANO, TX 75093
Fax# 972-612-1601

I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS FROM:

□ SLEEP CENTERS OF TEXAS
3600 GASTON AVE., #1053, LB 102
DALLAS, TX 75246
Fax# 214-827-2860

□ SLEEP CENTERS OF TEXAS
3604 N. PRESTON RD. # 300
PLANO, TX 75093
Fax# 972-612-1601

TO/FROM ____________________________________ (To be filled in by Sleep Centers of Texas)
____
____

THE LATEST HISTORY AND PHYSICAL IN YOUR POSSESSION CONCERNING MY ILLNESS.

NAME____ SS# ____________________
DOB ____________________

ADDRESS __________________________________
____
____

SIGNATURE_____________________________________ DATE __________________

1.800.SNORING · 1-800.766.7464
WWW.SLEEPCENTERSOFTEXAS.COM

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how we may use and disclose your protected health information ("PHI") to carry out treatment, payment or health care operations and for other purposes permitted or required by law. This Notice also describes your rights to access and control your PHI. Your PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment. We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis or treat you.

Payment. Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan provider to obtain approval for the hospital admission.

Health Care Operations. We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room area when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your consent or authorization: (1) when disclosure is required by federal, state or local law; judicial, board, or administrative proceedings; or law enforcement; (2) if disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority; (3) if disclosure is required by a search warrant lawfully issued to a government law enforcement agency; (4) if disclosure is compelled by the patient or the patient's representative pursuant to state health and safety codes or to corresponding federal statutes or regulations; (5) to avoid harm; (6) if disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threat; (7) if disclosure if mandated by the state child abuse and neglect reporting laws; (8) if disclosure is mandated by the state elder abuse reporting laws; (9) if disclosure is permitted by the fact that you tell us of a serious or imminent threat of physical violence by you against a reasonably identifying victim or victims; (10) for public health activities (such as to the coroner); (11) for health oversight activities; (12) for specific government activities; (13) for research activities (such as medical research); (14) for Worker's Compensation purposes; (15) appointment reminders and health-related benefits or services; (16) if an arbitrator or arbitration panel compels disclosure; (17) if disclosure is required or permitted to a health oversight agency for oversight activities authorized by law (such as required by the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration); and (18) if disclosure is otherwise specifically required by law (such as to funeral directors or for organ donations).

We may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment of your health care, unless you object in whole or in part. Retroactive consent or consent after the fact may be obtained in emergency situations.

In any other situation not described above, we will request your written authorization before using or disclosing any of your PHI. Even if you sign an authorization to disclose your PHI, you may revoke that authorization in writing, to stop any future uses and disclosures (assuming that we have not taken any actions subsequent to your original authorization) of your PHI to us.

You may revoke or cancel the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. The following is a statement of your rights with respect to your PHI:

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction(s) requested and to whom you want the restriction(s) to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care professional.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You may exercise this right by contacting our HIPAA Compliance Office or the contact person below.

You have the right to receive confidential communication from us by alternative means or at an alternative location. You may exercise this right by contacting our HIPAA Compliance Officer or the contact person below.

You have the right to obtain a paper copy of this Notice upon request, even if you have agreed to accept this Notice alternatively (*i.e.* electronically). You may exercise this right by contacting the receptionist in our office.

You may have the right to have your physician amend your PHI. If we deny your request for amendment or alteration, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You may exercise this right by contacting our HIPAA Compliance Officer or the contact person below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. You may exercise this right by contacting our HIPAA Compliance Officer or the contact person below.

We reserve the right to change the terms of this Notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints. You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling such a complaint.

This Notice was published and becomes effective on or before [date printed].

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this Notice, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

For further information about our privacy practices, please contact: Kathy Blackburn, who can be contacted at 972-612-1600.

Your signature below is only to acknowledge or admit that you have received this Notice of our privacy practices.

Print Name: ______________________________________

Signature: ______________________________________ Date: _________________________

sleep centers OF TEXAS

Sleep and Medical History

Today's Date: ______________________

Name: ____ Age: ___________ Primary MD: ______________________

SSN: ___________________________ Height: _________ Weight: ________ Referring MD: ______________________

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions **as thoroughly as you can.**

All answers should refer to a typical night (or day) of sleep.
If you are already using CPAP, answer according to when you are wearing the mask.

Annotate your main problem(s):

( ) Act out dreams ( ) Hard to fall asleep ( ) Hold breath when sleeping ( ) Snore ( ) Too tired
( ) Gasp or Choke ( ) Hard to stay asleep ( ) Legs kick/move ( ) Too sleepy ( ) Usually feel un-rested
( ) Other: ____

General Sleep:

1. For how long have you had this problem?
   ( ) Only within the last month ( ) 1-6 months ( ) 6 months – 2 years ( ) > 2 years

2. Rate the severity of your problem.
   ( ) Mild ( ) Moderate ( ) Severe ( ) the problem is only for others

3. Is it getting worse?
   ( ) No ( ) Yes ( ) Do not know

5. Does your sleep problem negative impact ….your work performance? ( ) No ( ) Yes
   ….your sex life? ( ) No ( ) Yes
   ….your quality of life? ( ) No ( ) Yes
   ….your social activity? ( ) No ( ) Yes

6. Do any other members of your family have significant sleep problems? ( ) No ( ) Yes
   If yes, please explain:____

7. Do you use any medication or other substance to help you sleep? ( ) No ( ) Yes
   If yes, please list name, dose, frequency, length of usage:_______________________________________

8. Have you ever discussed these sleep problems with another doctor?

   ( ) No ( ) Yes… Dr. name: ________________Diagnosis:__________________________________

   List present sleep treatment: ____ date started:____________________

   List prior sleep treatment: ____ dates:__________________________

N = Never	O = Occasionally	F = Frequently

Please rate how often *you or others* have noted that you:

Snore	N	O	F
Snore loudly enough that others complain	N	O	F
Awaken from sleep feeling short of breath, gasping, or choking	N	O	F
Hold your breath or stop breathing while asleep	N	O	F
Experience other breathing problems at night	N	O	F
Have headaches upon waking that improve in less than 2 hours	N	O	F
Have dry mouth upon waking	N	O	F
Sweat excessively at night	N	O	F
Experience heart pounding or beating irregularly during the night	N	O	F

Feel sleepy or tired during the day	N	O	F
Awaken feeling unrested or unrefreshed	N	O	F
Get sleepy while driving	N	O	F
Have had a wreck due to sleepiness	N	O	F
Have trouble at work or school because of sleepiness	N	O	F
Become irritable or "crabby"	N	O	F
Experience decrease in memory or concentration abilities	N	O	F

(DOCTOR ONLY)

ESS=____

Prtnr=____

Fall asleep involuntarily or suddenly or in awkward situations	N	O	F
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying	N	O	F
Feel totally unable to move (paralyzed) when first waking or falling asleep	N	O	F
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep (similar to hallucinations)	N	O	F
Find yourself doing complex tasks of which you were totally unaware (such as driving/navigating without conscious awareness)	N	O	F

Have nightmares or night terrors	N	O	F
Act out your dreams	N	O	F
Walk in your sleep	N	O	F
Do anything else considered "unusual" while asleep	N	O	F

Recurrently or rhythmically move, twitch or jerk your legs **while asleep**	N	O	F
Feel restlessness, agitation or discomfort in your legs **at or before bedtime**	N	O	F

If so…..

Do you feel an overwhelming urge to move your legs?	( ) No	( ) Yes
Does it happen only in the evening?	( ) No	( ) Yes
Does it happen only when relaxed?	( ) No	( ) Yes
Does it get better if you move about or walk?	( ) No	( ) Yes
Does it disturb sleep or sleep onset?	( ) No	( ) Yes

How often do you experience this? ___________days per **week** or **month** *(circle one)*

Sleep Hygiene:

1. Do you often have anxiety (worry about things) around bedtime? ( ) No ( ) Yes
2. Do you often feel sad or depressed? ( ) No ( ) Yes

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3. Do you sleep better away from home than in your own bed? ( ) No ( ) Yes
4. Do you have thoughts racing through your mind while trying to go to sleep? ( ) No ( ) Yes
5. Do you get anxious or upset when you are unsuccessful with falling asleep? ( ) No ( ) Yes

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6. Do you usually take coffee, tea, or chocolate within 2 hours before you go to bed? ( ) No ( ) Yes
7. Do you do physical exercise within 2 hours before bedtime? ( ) No ( ) Yes
8. Do you watch TV or read in bed before falling asleep? ( ) No ( ) Yes
9. Do you ever sleep, nap, or rest during the awake portion of your day? ( ) No ( ) Yes

   If yes… how often? ___________ # per day ____________ total per week

   …on average, how long is your nap? ( ) less than 1 hr ( ) 1 hr or more

   …after a nap do you still remain tired? ( ) No ( ) Yes
10. Check any condition that routinely applies to you:

   ( ) sleep with someone else in your bed ( ) sleep with a pet in your room ( ) sleep by yourself
   ( ) provide assistance to someone during the night (child, invalid, bed partner, animal)
11. Check any factors that disturb your sleep:

   ( ) heat ( ) cold ( ) light ( ) noise ( ) bed partner ( ) other: _________________

Sleep Habits:

12. You feel your best during ( ) Morning ( ) Afternoon ( ) Evening
13. Estimate your total **actual sleep per night?** (do not include time awake in bed) ______________________
14. What time do you **usually go to bed?** **on WORKDAYS? ___________** **on NON-WORKDAYS? ____________**
15. What time do you **usually rise from bed?** **on WORKDAYS? ___________** **on NON-WORKDAYS? ____________**
16. How long does it **usually** take you to **fall asleep**? ____
17. How many hours of sleep do you feel you **need** in order to feel your very best? ______________________
18. In a perfect world, what would be your choice for an **ideal hour** to go to bed? _____________ To awaken? ____________
19. In your opinion, what usually **prevents** you from quickly falling to sleep? ____
20. How many times do you **typically wake up** at night? ____________________Cause?____
21. If you wake up, **on the average,** how long do you **stay awake?** ____
22. If you do awaken during the night, in which part(s) of your sleep period is it predominantly?
    ( ) soon after falling asleep ( ) middle of the night ( ) near end of sleeping period

Current Medications:

****Please list all medicines prescribed by your doctor and their dosages****

_____________________________________ ____

_____________________________________ ____

________________________________ ____________________________________

________________________________ ____________________________________

MEDICAL HISTORY

Past Medical History:

[Please check any condition that a *doctor has diagnosed* you with:]

Cardiac/Heart: (C:)	**Digestive:** (D:)	**Endocrine/Other:** (E:)	**Lung/Pulmonary:** (L:)	**Neurology:** (N:)	**Psychology:** (P:)
[ ] Anemia	[ ] Acid reflux (GERD)	[ ] Arthritis/chronic pain	[ ] Asthma	[ ] Headache	[ ] Alcoholism
[ ] Angina	[ ] Diverticulitis	[ ] Back pain	[ ] Bronchitis	[ ] Infection of brain/ spinal cord	[ ] Drug abuse
[ ] CHF (heart failure)	[ ] Hiatal hernia	[ ] Chronic fatigue syn	[ ] COPD	[ ] Injury of brain/spinal cord	[ ] Depression
[ ] Elevated lipids (cholest.)	[ ] other digestive probs	[ ] Fibromyalgia	[ ] Emphysema	[ ] Nerve damage	[ ] Suicide attempt
[ ] Heart attack		[ ] Diabetes	[ ] other Lung probs.	[ ] Seizure/epilepsy	[ ] Anxiety
[ ] High blood pressure		[ ] Thyroid disease		[ ] other Brain/Nerve disorders	[ ] Panic attacks
[ ] Stroke		[ ] Sickle cell			[ ] OCD
[ ] Other heart problem		[ ] Kidney disease			[ ] ADD/ADHD
		[ ] Cancer			

[ ]Other____

Medication Allergies:

[Are you allergic to any medications? (Please list)]

________________________ ___________________________ ___________________________

Past Surgical History:

[Please list any operations and approximate date of surgery.]

Date	Type of Surgery	Date	Type of Surgery
________	___________________	_______	__________________________
________	___________________	_______	__________________________

Family History:

[Has anyone in your *blood-related* family ever been afflicted with:]

☐ Acting out dreams	☐ Excessive sleepiness	☐ Narcolepsy	☐ Sleep walking
☐ Depression	☐ Heart attack	☐ Restless legs	☐ Stroke
☐ Diabetes	☐ Hypertension	☐ Sleep apnea	☐ Suicide

Social History:

Marital Status: S M D W Occupation: __________________________________

[Please check all that apply:]

Children at home	☐ None	☐ Grown/gone	☐ Yes: ages _____________		
Others at home	☐ None	☐ Spouse	☐ Friend	☐ Parents/grandparents	☐ other
Alcohol	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Alcoholic
Tobacco	☐ None	☐ Yes – type ______________________		How much __________________	
Recreational drugs	☐ None	☐ Yes – type ______________________		Frequency __________________	

Other:

Personal assessment of current health: Poor__ Fair__ Good__ V.Good__ Excellent__
Weight gain in the past 12 months: None_____ amt:_____lbs
Weight loss in the past 12 months: None_____ amt:_____lbs
Most you have *EVER* weighed *(non-pregnant)*: ________lbs In what year? _______

(DOCTOR ONLY)
Today:
_______lbs

REVIEW OF SYSTEMS

[Do you presently, or have you in the recent past, suffered from any of the listed items? (check all that apply)]

Constitutional

- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weight Loss

Eyes

- ☐ Pain
- ☐ Visual changes
- ☐ Discharge
- ☐ Double vision

Ear, Nose, Throat and Allergy

- ☐ Trouble breathing through nose
- ☐ Night time congestion
- ☐ Trouble swallowing
- ☐ Hoarse voice
- ☐ Frequent nosebleed
- ☐ Swollen glands
- ☐ Frequent infections
- ☐ Frequent hives
- ☐ Frequent colds
- ☐ Nasal/Seasonal allergies

Heart

- ☐ Chest pain while awake
- ☐ Chest pain while asleep
- ☐ Very rapid heart beat
- ☐ Irregular heartbeat
- ☐ Leg swelling
- ☐ Pains in legs when walking

Lungs

- ☐ Chronic cough
- ☐ Cough up blood
- ☐ Pain with breathing
- ☐ Short of breath w/mild exertion
- ☐ Trouble breathing laying flat

Digestive

- ☐ Frequent nausea/vomiting
- ☐ Frequent indigestion
- ☐ Frequent diarrhea/constipation
- ☐ Frequent bloating
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Abdominal pain

Genital/Urinary

- ☐ Blood in urine
- ☐ Frequent nighttime urination

MALE: ☐ Trouble with erection
- ☐ Testicular pain or swelling

FEMALE :☐ Irregular periods
- ☐ No period any longer

Musculoskeletal

- ☐ Joint pain or swelling
- ☐ Back pain (chronic)
- ☐ Muscle pain or weakness
- ☐ Leg cramps

Nervous System

- ☐ Frequent headaches
- ☐ Loss of strength in specific body area
- ☐ Loss of feeling in specific body area
- ☐ Fainting spells
- ☐ Trouble with balance
- ☐ Trouble with coordination
- ☐ Dizziness
- ☐ Trouble walking

Psychiatric

- ☐ Hallucinations
- ☐ Nightmares
- ☐ Feel depressed
- ☐ Feel nervous or tense
- ☐ Suicidal thoughts

Endocrine

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Sexual dysfunction
- ☐ Hot flashes
- ☐ Urinating frequently

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
Sitting and reading	____
Watching TV	____
Sitting, inactive in a public place (e.g. a theater 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 lunch without alcohol	____
In a car, while stopped for a few minutes in traffic	____
	Total: ______

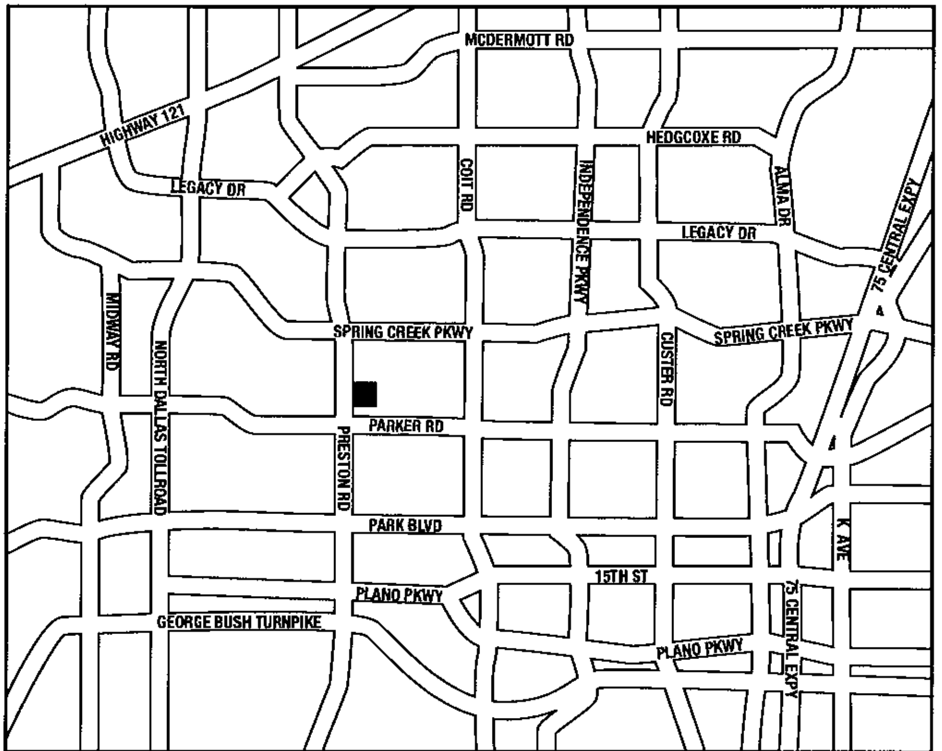
FOR DOCTOR USE ONLY

☐ Rest of Review of Systems is otherwise negative
☐ Entire Questionnaire reviewed with patient this date ________________________
☐ Sleep Study Order in chart with CPT for consult.
☐ Sleep aid policy & script explained to patient.

_______________________________________ _______________________________________
Reviewing Practitioner

sleep centers
OF TEXAS

3604 N. Preston Rd., Suite 300
Plano, TX 75093
972.612.1600
972.612.1601 Fax



Sleep
Centers
of Texas

Pres. George Bush
Turnpike
190
121
Custer Rd.
North Central Expy.
75
North Dallas Tollroad
190
35E
Beltline Rd.
Beltline Rd.
Coit Rd.
75
635
DFW
Int'l
Airport
North Central Expy.
75
Garland Rd.
TX-161
Beltline Rd.
114
LOOP
12
LOOP
12
North Dallas Tollroad
N. Buckner Blvd.
635
161
183
183
360
Hampton Rd.
30
80
S. Buckner Blvd.
30
175