



Sleep Medicine Associates

7103 Bakers Bridge Ave. 102

Brentwood TN, 37027

P – 615-732-5712 F – 615-634-8350

Date: _____ Patient Name: _____

DOB: _____ Patient Height: _____ Weight: _____ lbs

Referring Physician: _____ Neck Size: _____

Main Sleep Problems:

1. My main sleep complaint is: _____ Trouble Sleeping at night _____ Sleepy during the day
 _____ Unusual behavior during sleep (gaspings, snoring, kicking, etc.)

Explain: _____

2. How many nights per week do you have a sleep problem? _____ nights/wk.
3. Have you been diagnosed with a sleep problem in the past? _____ yes _____ no If yes, briefly explain:

4. Does your sleep problem disturb your bed partner? _____ yes _____ no

Sleep Schedule

5. On normal weekdays Bedtime: _____ a.m./p.m. Wake up: _____ a.m./p.m.

6. On days off Bedtime: _____ a.m./p.m. Wake up: _____ a.m./p.m.

7. Do you maintain a fairly regular sleep/wake schedule? _____ yes _____ no

8. Do you take naps frequently? _____ yes _____ no

If so, do they make you feel refreshed? _____ yes _____ no

9. Do you read or watch TV in bed? _____ yes _____ no

Falling Asleep:

10. Do you often have trouble falling asleep? _____ yes _____ no

11. Do you wake up too early without being able to fall back asleep? _____ yes _____ no

12. On average, how long does it take to fall asleep? _____ hrs _____ min.

13. On average, how many times do you awaken during the night? _____

Movements During Sleep

14. Do you awaken yourself by kicking or jerking your legs? _____ yes _____ no

15. Does your bed partner complain of your leg movements? _____ yes _____ no

16. Do you ever have a restless, aching or burning sensation in your legs prior to going to sleep?

_____ yes _____ no

17. Do you exercise regularly? _____ yes _____ no

18. Do you have any other movements in your sleep (walking, tooth grinding, etc.) _____ yes _____ no

If yes, briefly explain: _____

19. Do you currently have nightmares or night terrors? _____ yes _____ no

Snoring



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- 20. Have you ever been told you snore? _____ yes _____ no
- 21. Have you ever been told you stop breathing during sleep? _____ yes _____ no
- 22. Do you have frequent headaches in the morning? _____ yes _____ no
- 23. Is your throat dry or sore in the morning? _____ yes _____ no
- 24. Have you ever had trauma or surgery to your upper airway? _____ yes _____ no
- 25. If yes, briefly explain: _____

Other Symptoms:

- 26. Do you ever experience hallucinations when falling asleep or waking up? ___yes ___no
- 27. Do you ever experience paralysis or inability to move while awake in bed? ___yes ___no
- 28. Do you ever experience a sudden loss of muscle tone associated with a change in emotion, such as laughter, anger, etc? _____ yes _____ no

Medical History:

29. List any current medical problems such as high blood pressure, heart or lung disease, stroke, diabetes etc.:

30. Are you allergic to any medications? _____ yes _____ no

If so, what? _____

31. Have you smoked cigarettes? _____ yes _____ no

How many years? _____ What year did you quit? _____

Do you currently smoke? _____ yes _____ no

How many packs per day? _____

32. On average, how many caffeinated drinks do you consume per day? _____/day

33. On average, how many alcoholic drinks do you consume per day? _____/day

Family History

34. Does anyone in your family have a sleep problem? _____ yes _____ no

If yes, briefly explain:

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=never doze 1= slight chance 2=moderate chance 3=high chance

Situation

Sitting and reading _____

Watching television _____



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Sitting inactive in a public place (a meeting, theater, etc.) _____

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 with someone _____

Sitting quietly after a lunch without alcohol _____

In a car while stopped for a few minutes in traffic _____

TOTAL _____

AUTHORIZATIONS:

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Sleep Medicine Associates and/or TSM for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers of Medicaid and Medicare or other insurance carriers and its agents any information needed to determine these benefits or the benefits payable for related services. _____ (Initial here)

I understand and agree to be personally and fully responsible for payment if my health insurance denies payment for services rendered, due to: a referral/precertification has not been issued for the services; my insurance is not in effect for the date of service; or if these services are non-covered for any reason. _____ (Initial here)

Patient Signature or Representative Date

HIPAA Privacy Act

Federal Regulation called Health Insurance Portability and Accountability Act requires us to provide you with the opportunity to review our Privacy Notice. This notice provides you with information about how we may use and disclose Protected Health Information about you.

Your response to the following questions will give us permission to contact you at home and/or work (if you so desire) and to whom we may disclose your medical information, other than as outlined in the Notice of Privacy Practices.

May we call you at home? _____ YES or _____ NO
May we leave a message on your answering machine? _____ YES or _____ NO

May we disclose your Protected Health information to anyone other than yourself? _____ YES or



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_____ NO

If YES, to whom may we talk to?

Can we talk to you at work? (Messages will not be left at work) ___ YES or ___ NO or ___ N/A

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health Information.

Patient Signature or Representative Date

Witness Signature Date

Patient Name: _____ DOB _____

Please review the following statements and initial next to each item after reading:

The complex polysomnogram (sleep study) and/or CPAP titration test(s) have been explained to me. My physician has explained the need for the test(s) to me and I have agreed to have the test(s) performed.
_____(Initial here)

I understand the polysomnography technician is not a physician and therefore cannot diagnose my condition. _____(Initial here)

I understand that the Sleep Medicine Associates and/or TSM will submit my claim to my insurance provider(s) for reimbursement on my behalf. I understand that I am responsible for non-covered or unpaid services. _____(Initial here)

Patient Signature or Representative Date

Video/Photo Consent



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I, _____, consent to having my photo taken as part of my medical record as well as being videotaped for the duration of my sleep study. I understand that this solely for the purpose of my accurate diagnosis and will not be shared with any other source.

Patient Signature or Representative Date

Professional Services Agreement

I understand and agree that Sleep Medicine Associates and/or TSM will forward my test result to the Facility's Medical Director and/or **Interpreting M.D.** for the purpose of the **professional interpretation** of my test results. I agree and understand to be personally and fully responsible for payment if my health insurance denies payment for services rendered, due to: a referral/precertification has not been issued for the services; my insurance is not in effect for the date of service; or if these services are non-covered for any reason. _____ (initial here)

I understand and agree that I may be balanced billed any portion not covered by my health insurance plan for the professional interpretation
by _____

_____ (initial here)



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Patient Name Printed

Patient Signature or Representative

Date

Date: _____

Patient Name (Last, First): _____

Patient Address _____

City _____ State & Zip _____

Home # (____) _____ Work # (____) _____ Cell # (____) _____



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Date of Birth _____ Age _____ Gender: _____ Female _____ Male

Social Security # _____

Marital Status: _____ Married _____ Single _____ Widowed _____ Divorced _____ Other

Race: _____ American Indian or Alaska Native _____ Asian _____ Black or African American
_____ Native American or Other Pacific Islander _____ White _____ Decline

Ethnicity: _____ Hispanic or Latino _____ Non-Hispanic or Latino _____ Decline

Preferred Language: _____

Is the patient a student? _____ Full Time _____ Part Time _____ No

Is the patient employed? _____ Full Time _____ Part Time _____ No

Patient's Employer/Address _____

Emergency Contact Person/Relationship _____

Emergency Contact Person's Phone Number: _____

INSURANCE INFORMATION:

Primary Policy Name: _____

Primary Policy Holder's Name _____ DOB: _____ SS# _____

Secondary Policy Name: _____

Secondary Holder's Name _____ DOB: _____ SS# _____

NAME: _____ DOB: _____

1. Have you ever had a sleep study, when? _____
Where? _____



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2. Are you currently using a CPAP or BIPAP machine? _____

What pressure? _____

3. Are you currently using supplemental oxygen? _____ What LPM? _____

Please check all that apply to you:

- Diabetes
- GERD/Reflux
- Heart Disease
- Cancer
- Thyroid Disease
- High Blood Pressure
- Tonsillectomy
- Nasal Surgery
- Deviated Septum
- Lung Disease
- Seizure Disorder
- COPD

Other: _____

Please list all medications you are currently taking:
Name and Dose:
