New Patient Paperwork- Dr Martha Hagaman

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Date: _____ Patient Name: _____
DOB:_____PatientHeight: _____ 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 (gasping, 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:_____p.m. Wake up: ____
6. On days off Bedtime:_Wake up: _____ a.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? _____times___

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 _____n.)
(cont)
If yes, briefly explain: tooth grinding, groaning, leg slamming___
19. Do you currently have nightmares or night terrors? _____ yes _____no

Snoring

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.: ___Prediabetes, chronic migraine, PTSD, anxiety, depression, IBS, bone marrow donor, diarrhea, allergic rhinitis, central sensitization to pain_____

30. Are you allergic to any medications? _____ yes _____no If so, what? _____Sulfa antibiotics (bactrim)_____ 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: O=never doze 1= slight chance 2=moderate chance 3=high chance

Situation_ _____Sitting and reading _____ Watching television _____

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 the 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_____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 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 is 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)_____

Patient Name Printed _____
Patient Signature or Representative Patient Name (Last, First):
_____
Patient Addres_____
City_____Franklin____ State & Zip_____TN _____ Home # _____

Work # _____ Cell # _____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: _____English_____

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? ____No_____ Where? _____
2. Are you currently using a CPAP or BIPAP machine? ___No_____ What pressure? _____
3. Are you currently using supplemental oxygen? _____No_____ 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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____