
Full Name: _____ Date of Birth ____ / ____ / ____

Sex: ____ Male _____ Female Social Security Number _____ / ____ / _____

Mailing address: _____

City:_____ State:_____ Zip Code:_____

Home Phone: ( ) _____-_____ Cell: ( )_____-_____

Marital Status (Please circle one) Single Married Separated Divorced Widow/Widower

Language: _____ Race: _____

E-mail address: _____

Pharmacy:_____ Phone:_____

Are you currently using a DME (Durable Medical Equipment) Company? If yes _____

## Insurance Information

Responsible party for paying bill: Patient Parent Spouse Other

Primary Insurance name: _____ Phone number: _____

Subscriber ID: _____ Group number: _____

Secondary Insurance name: _____ Phone number: _____

Subscriber ID: _____ Group number: _____

## Emergency Contract

Name: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____

Referring provider: _____


## ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT

Due to the Health Insurance Portability and Accountability Act (HIPAA_ of 1996), the following information must be filled out by each patient annually.

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment. I give Lung & Sleep Specialist of North Texas, providers and employees my permission to discuss freely my conditions, treatment or diagnosis with the person present. YES or NO

Please mark if we may leave a detailed message:

Home Phone Work Cell Phone Email:_____

May we call your name out in the Lobby? YES or NO

With whom may we discuss your information about your care, treatment and Diagnosis?

Name:_____ relationship:_____ phone:_____

Name:_____ relationship:_____ phone:_____

## Office Policy on Payments

Payment is due at the time services are rendered, unless prior arrangments have been made with the Office manger. This includes co pays, coins and deductibles.

Our practice charges a $25.00 fee for Returned Checks, Medical records request, FMLA and Disability forms that need to be completed.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

## Authorization for release of medical records

I authorize the Lung and Sleep Specialists of North Texas to release any medical information including diagnosis, radiograph, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for the information.

**I have read the above and accept financial responsibility in full for this account.**

Signed:_____ Date:_____


## MEDICATION PRESCRIPTION POLICY & AGREEMENT

The following is an outline of our medication prescription refill policy at Lung and Sleep Specialists of North Texas

1. Please call your pharmacy for any refills. Your pharmacy will call or fax us a request.
2. We require a 24hr notice on refills. To ensure you don't run out.
3. We DO NOT refill medications after business hours or on weekends.
4. Any medication refills received after 4:00 pm will be addressed the next business day.
5. Samples will only be given out if you are compliant with your visits as scheduled.

## AFTER BUSINESS HOURS & WEEKENDS

Our business hours are 8:30am to 5:00pm Monday through Thursday, Friday 8:30am to 2pm. In the case of an emergency, life-threatening situations, or concerning symptoms, call 911 or proceed to the nearest emergency room.

Our providers do NOT have access to your health information records after business hours or weekends.

All routine appointments must be made during our business hours listed above.

## Appointment Cancellation Policy

We require a 24 hr notification for all cancelations. If you fail to notify our office within 24 hrs we charge a "NO SHOW" fee for routine follow up visits $25/New patients $50/PFT $100/Sleep Study $100.

A great deal of time and preparation is put into assuring your appointment time is customized to your needs and we provide ourselves in making sure you are given the appropriate time and attention you deserve regarding your medical care. Please help us ensure that we can continue that level of care by giving us the courtesy of timely cancellations so that we may give that same attention to others in need.

Please bring all your medications to your appointment. A list of name, strength and how you take or you may bring bottles.

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

I have read and understand the above policies and agree to adhere to the policies.

Signature:_____ Date:_____

**Please check ALL that apply within the last SIX (6) months**


Constitutional
- ☐ Good general health lately
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches
- ☐ Snoring
- ☐ Hoarseness
- ☐ Arthritis
- ☐ Abnormal chest x-ray

Eyes
- ☐ Eye diseases or injury
- ☐ Wear glasses or contacts lenses
- ☐ Blurred or double vision
- ☐ Glaucoma

ENT
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Earaches or drainage
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breathe or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Sudden heart beat changes
- ☐ Swelling of feet, ankles, or hands

Respiratory
- ☐ Frequent coughing
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Asthma/wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Change in bowel
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movement or constipation
- ☐ Blood in stool
- ☐ Stomach pain

Genitourinary
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force when urinating
- ☐ Incontinence or dribbling
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Male-Testicle pain
- ☐ Female-irregular periods
- ☐ Female-Vaginal discharge
- ☐ Female # of pregnancies _____
- ☐ # of miscarriages_____

Female last pap smear _____
was it normal Yes or No

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Weakness of muscle or joints
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty in walking

Skin
- ☐ Rash and itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

Neurological
- ☐ Frequent or reoccurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsion or seizures
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke
- ☐ Head injury

Psychiatric
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep problems

Endocrine
- ☐ Glandular or hormone problems
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance
- ☐ Dry Skin
- ☐ Change in hat or glove size

Hematologic/Lymphatic
- ☐ Slow to heal after surg
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Phlebitis
- ☐ Past transfusion
- ☐ Enlarge glands

Allergic/Immunogic
- ☐ History of skin reaction

Or other adverse reactions to:
- ☐ Penicillin or antibiotics
- ☐ Morphine, Demerol, narcotics
- ☐ Novocaine or anesthetic
- ☐ Aspirin or other OTC pain meds
- ☐ Tetanus antitoxin or other serum
- ☐ Lodine, methiolate, or other antiseptics
- ☐ Other drug allergies _____
- ☐ Food allergies _____ _____

Surgical history:_____


_____

Past chest x-rays: List most recent first and location

_____

_____

Smoking history:
Have you ever smoked? Yes or No How many packs per day?_____
Exposure to second hand tobacco smoke? Never rarely occasionally often regularly

Occupational/Hobbies/Activities:
List any jobs or activities where you exposed routinely to chemicals, powders, dusts, other types of hazardous materials (i.e. ceramics or remodeling).

| Years of exposure | Type of hazardous exposure (i.e. Powder, dust, fumes, chemicals, household cleaners) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Weight loss or gain: Yes or No

Social activities:
Alcoholic beverages? Beer Wine mixed drinks hard liquor
Substance abuse now or in the past? Marijuana Cocaine Narcotics Valium LSD
IV drug use

Family history:

| Parents | Alive | Deceased age |
|---|---|---|
| Mother | ☐ | ☐ _____ |
| Father | ☐ | ☐ _____ |
| Brother | ☐ | ☐ _____ |
| Brother | ☐ | ☐ _____ |
| Sister | ☐ | ☐ _____ |
| Sister | ☐ | ☐ _____ |
| Mothers side: | | |
| Grandfather | ☐ | ☐ _____ |
| Grandmother | ☐ | ☐ _____ |
| Fathers side: | | |
| Grandfather | ☐ | ☐ _____ |
| Grandmother | ☐ | ☐ _____ |

Respiratory symptoms:
Answer if you have shortness of breath


- ☐ On exertion
- ☐ At rest
- ☐ When lying flat

How long have you had symptoms?

- ☐ Less than 6 months
- ☐ 6 – 12 months
- ☐ 1 – 3 years
- ☐ 3 – 5 years
- ☐ 5 – 10 years
- ☐ Greater than 10 years

Does your shortness of breath improve after coughing up sputum? Yes or No
Does your shortness of breath come on suddenly? Yes or No
Is your shortness of breath associated with any of the following symptoms?

- ☐ Drenching sweat
- ☐ black outs
- ☐ pounding heart
- ☐ chest pain
- ☐ wheezing
- ☐ Swollen legs
- ☐ fever
- ☐ chills
- ☐ nausea

Cough:
How long have you had trouble with coughing?

- ☐ Less than 1 month
- ☐ 1 – 3 months
- ☐ 3 months to a year
- ☐ 1 – 2 years
- ☐ More than 2 years

Has your cough changed recently? Yes or No
Does your cough produce sputum? Yes or No
If yes, what color?

- ☐ Clear
- ☐ Yellow white
- ☐ Green
- ☐ Tan
- ☐ Brown red
- ☐ Other

How much sputum do you produce over 24 hrs?

- ☐ Less than 2 tablespoons
- ☐ More than 2 tablespoons

Chest pain:
When do you experience chest pain? On exertion at rest after meals
How long does pain last? Few seconds 5 minutes 15 minutes 1 hour all day
How many years have you had chest pain? 1-3 years more than 3 years
What makes the pain go away? Resting eating


# Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

| Situation | Chance of Dozing or sleeping |
|---|---|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Being a passenger in a motor vehicle For an hour or more | _____ |
| Lying down in the afternoon | _____ |
| Sitting and talking to someone | _____ |
| Sitting quietly after lunch (no alcohol) | _____ |
| Stopped for a few minutes in traffic while driving | _____ |
| Total: | _____ |

Name: _____ Date: _____

1200 Clear Lake Road, Weatherford, TX 76086


Dear Patient,

Sleep problems are extremely common. Breathing disorders of sleep alone affect 4% of women and 9% of men between the ages of 30 and 60 in this country. Insomnia is present in 15% to 20% of the population on chronic basis. All of these disorders affect daytime wakefulness to different degrees in each person. For instance, some people with moderately severe apnea claim to have little or no symptoms to daytime fatigue, while some individuals who only manifest snoring during sleep may feel terribly sleepy during the day. Obviously, each person must use his or her best judgement to determine if placing himself or herself in a particular setting/situation (for example: driving a car, using heavy machinery, or working at heights) which might lead to them harming himself, herself or others.

You should be aware that any nighttime sleep disturbance may cause daytime drowsiness and therefore could impair your ability to operate heavy machinery, especially a motor vehicle. You should not expose yourself to others to harm because of your potential drowsiness.

For your protection we require verification that you have received this notice. Therefore, please sign below and bring with you to your appointment.

Patients signature:_____ Date:_____

Sleep Questionnaire:

Please complete this questionnaire as it will help the providers help you. Some questions are personal, you may leave blank and discuss them with the provider if you wish.

Please briefly describe your sleep complaints, including when they started.

_____

_____

_____

| | | | | |
|---|---|---|---|---|
| Did you have a problem with your sleep as a child? | ❑ | Yes | ❑ | No |
| Are you unable to fall asleep at night? | ❑ | Yes | ❑ | No |
| Are you unable to remain asleep at night? | ❑ | Yes | ❑ | No |
| Do you commonly wake up earlier than you would like? | ❑ | Yes | ❑ | No |
| Do you use an alarm clock to wake up in the morning? | ❑ | Yes | ❑ | No |
| Is it easy for you to get out of bed in the morning? | ❑ | Yes | ❑ | No |
| Do you feel you get too much or not enough sleep at night? | ❑ | Yes | ❑ | No |
| Do you feel that the quality of your sleep is unsatisfactory? | ❑ | Yes | ❑ | No |
| Have you ever been told you snore? | ❑ | Yes | ❑ | No |
| Does your snoring disturb others in your home? | ❑ | Yes | ❑ | No |
| Do you sometimes wake up choking, breathing hard, or gasping for a breath? | ❑ | Yes | ❑ | No |
| Have you dreamed of drowning or being suffocated? | ❑ | Yes | ❑ | No |
| Do you wake up at night with heartburn? | ❑ | Yes | ❑ | No |
| Do you wake up coughing? | ❑ | Yes | ❑ | No |
| Do you sweat excessively during sleep? | ❑ | Yes | ❑ | No |
| Is your sleep often restless and disturbed? | ❑ | Yes | ❑ | No |
| Have you ever wet the bed during sleep as an adult? | ❑ | Yes | ❑ | No |
| Do you get an uncomfortable, hard to describe feeling in your legs or elsewhere that increases in intensity? | ❑ | Yes | ❑ | No |
| Do these worsen when sitting or lying down, especially in the late evening or night? | ❑ | Yes | ❑ | No |
| Does this feeling create a demanding need to move the legs or body to relieve the feeling? | ❑ | Yes | ❑ | No |
| Do you get relief of these symptoms by activity (walking, stretching, and bending) at least temporary? | ❑ | Yes | ❑ | No |
| Does pain disturb your sleep? If yes describe:_____ | ❑ | Yes | ❑ | No |


| | | | | |
|---|---|---|---|---|
| Do you commonly wake up in the morning with a sore throat or hoarseness? | ❑ | Yes | ❑ | No |
| Do you wake up in the morning with a headache? | ❑ | Yes | ❑ | No |
| Do you have hallucinations or dream like mental images during sleep? | ❑ | Yes | ❑ | No |
| Do you have attacks of sudden physical weakness or paralysis during the day? | ❑ | Yes | ❑ | No |
| If so does laughing, anger, or other emotional factors trigger the attacks? | ❑ | Yes | ❑ | No |
| Do you have hallucinations or dream like metal images when you are falling asleep or waking up? | ❑ | Yes | ❑ | No |
| Do you ever feel paralyzed when falling asleep or as you are waking up? | ❑ | Yes | ❑ | No |
| Do you often have frightening dreams or nightmares? | ❑ | Yes | ❑ | No |
| Do you ever wake up screaming? | ❑ | Yes | ❑ | No |
| Are you afraid of the dark or going to sleep? | ❑ | Yes | ❑ | No |
| Do you awaken during the night or in the morning with feelings of fear, anxiety, worry, depression, unhappiness, irritability, or confusion? | ❑ | Yes | ❑ | No |
| Do you tend to lie awake at night with thoughts racing through your mind? | ❑ | Yes | ❑ | No |
| Do you sleep walk? | ❑ | Yes | ❑ | No |
| Do you talk in your sleep? | ❑ | Yes | ❑ | No |
| Do you grind your teeth during sleep? | ❑ | Yes | ❑ | No |
| Do you wake up with pain in your jaw? | ❑ | Yes | ❑ | No |
| Are you bothered by itching sensations during the night? | ❑ | Yes | ❑ | No |
| Have you ever been told that you make rolling/rocking movements in your sleep? | ❑ | Yes | ❑ | No |
| Do you fall out of bed? | ❑ | Yes | ❑ | No |
| Do you eat or drink anything or take any medications during the night or after going to bed? if so what? _____ | ❑ | Yes | ❑ | No |
| Do you usually sleep with a bed partner? | ❑ | Yes | ❑ | No |
| Are you awake at night because of your bed partner? (because of your partners noise and movement) | ❑ | Yes | ❑ | No |
| Are you awake during the night because some other person or animal requires assistance? | ❑ | Yes | ❑ | No |
| Are you awake at night because of noise, heat, cold or light? | ❑ | Yes | ❑ | No |
| Do you rely on caffeine (coffee, tea, etc) to stay awake during the day? | ❑ | Yes | ❑ | No |
| Do you feel physically fatigued during the day even when you are not sleepy? | ❑ | Yes | ❑ | No |
| Is your daytime performance in work or recreation less efficient than you would like it to be? | ❑ | Yes | ❑ | No |
| Do you yawn very frequently during the day? | ❑ | Yes | ❑ | No |
| Do you feel distracted and unable to concentrate during the day? | ❑ | Yes | ❑ | No |
| If you take stimulants do you feel your performance is satisfactory when taking them? | ❑ | Yes | ❑ | No |
| Uncontrollable urge to fall asleep during the day or find yourself falling asleep when you don't want to? | ❑ | Yes | ❑ | No |
| Have you had any accidents or near accidents when driving a car due to extreme sleepiness or trouble concentrating? | ❑ | Yes | ❑ | No |
| Do you function poorly in the morning afternoon or evening | ❑ | Yes | ❑ | No |
| Are you claustrophobic? | ❑ | Yes | ❑ | No |
| Is your nose commonly congested or stuffy? | ❑ | Yes | ❑ | No |
| Does your pulse ever beat too fast or too hard (palpitations) during the day or night? | ❑ | Yes | ❑ | No |
| Have you ever had any head injuries? | ❑ | Yes | ❑ | No |
| Do you suffer from fainting spells or loss of consciousness during the day? | ❑ | Yes | ❑ | No |
| Do you feel that interest in sex is less than normal? | ❑ | Yes | ❑ | No |
| Do you have problems with reaching an orgasm (climax) during sex? | ❑ | Yes | ❑ | No |
| Women: | | | | |
| Are your menstrual periods abnormal or irregular? | ❑ | Yes | ❑ | No |
| Are you pregnant? | ❑ | Yes | ❑ | No |
| Are you past menopause or are you having menopausal symptoms now? | ❑ | Yes | ❑ | No |
| Men: | | | | |
| Do you wake up with penile erections that are painful? | ❑ | Yes | ❑ | No |
| Do you have problems obtaining or sustaining a penile erection? | ❑ | Yes | ❑ | No |
| Do you have problems ejaculating? | ❑ | Yes | ❑ | No |


Usual bedtime on workdays _____am/pm Days off _____am/pm

How long does it take to go to sleep on workdays? _____ minutes Days off _____ minutes

Usual time to get up on workdays _____am/pm Days off _____am/pm

How much sleep do you feel you get each night? _____ hours

Number of awakenings per night _____ how long do you stay awake? _____

Number of trips to the bathroom per night? _____

How long does it take you to become fully alert and functional in the morning? _____

If you take naps, how long are they? (including dozing while watching TV, reading, etc.)? _____

What time of day? _____ How many naps per week? _____

Family history of sleep disorder:

Does anyone in your family have sleep problems?

- ☐ Husband
- ☐ Wife
- ☐ Son
- ☐ Daughter
- ☐ Father
- ☐ Mother
- ☐ Other _____

Does anyone in your family psychiatric problems?

- ☐ Husband
- ☐ Wife
- ☐ Son
- ☐ Daughter
- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Other _____

Positive airway pressure is the most reliable and cost effective treatment for Obstructive Sleep Apnea. This treatment uses a small machine to produce air flow, pressure and a hose/headgear system that delivers the air to prevent the airway from collapsing during sleep. An open airway allows unrestricted breathing during sleep. Patients have a choice who they want to provide their equipment. If you have a Durable Medical Equipment company please provide Name: _____ Phone: _____

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

Signature: _____ Date: _____

If not filled out by patient please print name and relationship to patient.

_____


AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize name: _____ Fax: _____ to release the following information from the medial record of the below mentioned patient:

Name: _____ DOB: _____

This information is to be released to:

Lung and Sleep Specialists of North Texas
1200 Clear Lake Road
Weatherford, TX 76086
Phone: 817-594-9993
Fax: 817-594-9915

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information. At this time I am requesting the following:

_____Complete records

_____Records of care from _____ to _____ only

_____Records of care concerning the following condition(s)

_____

_____

_____other, specify_____

_____I understand that the information disclosed may contain testing or treatment information to mental health, drug and/or alcohol abuse, treatment of sexually transmitted diseases, HIV/AIDS virus.

The purpose of disclosure:

_____Continued patient care

_____Attorney/Legal

_____Insurance

_____Personal use

_____Other Specify_____

**I understand that you will provide this information with 15 days from receipt of this request (per Medical Practice Act of the Texas Medical Board) and that a fee for preparing and furnishing this information may be charged if records are being release to the patient for personal use.**

Signature:_____ Date:_____