# Sleep Solutions
OF MISSISSIPPI

PATIENT NAME______________________________

HOME PHONE______________________________ OTHER____________________

PHARMACY______________________________ PHONE____________________

ALLERGIES:____________________________________________________________

| DATE | MEDICATIONS | DOSAGE | FREQUENCY | STOP DATE |
|---|---|---|---|---|
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Sleep Solutions OF MISSISSIPPI

971 LAKELAND DRIVE, SUITE 752
JACKSON, MISSISSIPPI 39216

401 BAPTIST DRIVE, SUITE 401
MADISON, MISSISSIPPI 39110

**PATIENT REGISTRATION SHEET • PLEASE PRINT**

DATE

| | | | | | |
|---|---|---|---|---|---|
| PATIENT'S NAME | LAST | FIRST | | MIDDLE | |
| DATE OF BIRTH | | GENDER | | SOCIAL SECURITY # | |
| MARITAL STATUS | | DRIVERS LICENSE # | | | |
| MAILING | | | | | |
| ADDRESS | | | | | |
| ZIP | | CITY | | STATE | |
| PHONE | HOME | WORK | | CELLULAR | |
| FAX | | PAGER | | EMAIL | |
| EMPLOYER | | | | | |
| EMERGENCY CONTACT | | | | RELATIONSHIP | |
| PHONE | HOME | WORK | | CELLULAR | |
| FINANCIALLY RESPONSIBLE PARTY | | DATE OF BIRTH | | PHONE | |
| ADDRESS | | | | | |
| PRIMARY INSURANCE PROVIDER | | | | | |
| ADDRESS | | | | | |
| CITY | | STATE | | ZIP | |
| POLICY/ID NUMBER | | | | GROUP NUMBER | |
| INSURED NAME | | DATE OF BIRTH | | SOCIAL SECURITY # | |
| SECONDARY INSURANCE PROVIDER | | | | | |
| ADDRESS | | | | | |
| CITY | | STATE | | ZIP | |
| POLICY/ID NUMBER | | | | GROUP NUMBER | |
| INSURED NAME | | DATE OF BIRTH | | SOCIAL SECURITY # | |
| REFERRAL INFORMATION | REFERRED BY: | | | | |
| PERSONAL REPRESENTATIVE(S) | (List any family member or other person we may disclose your health information to.) | | | | |
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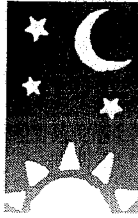
***PLEASE ALLOW THE RECEPTIONIST TO COPY YOUR INSURANCE CARD.***

**PLEASE READ AND SIGN THE BACK SIDE OF THIS PAGE**



Sleep Solutions
OF MISSISSIPPI

971 Lakeland Drive / Suite 752 / Jackson, MS 39216 / Telephone 601-362-3599 / Fax 601-362-3598
401 Baptist Drive / Suite 401 / Madison, 39110 / Telephone 601-853-1070 / Fax 601-853-0502

# Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Sleep Solutions of Mississippi and any assisting provider, for service rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________________ ______________

Your Signature Date

Method of Payment: MC/Visa ________ Check________ Cash ________

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

BENEFICIARY'S NAME: ______________________________

MEDICARE NUMBER: ______________________________

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to SLEEP SOLUTIONS OF MISSISSIPPI for any services furnished me by that physician/provider. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

______________________________ ______________

Signature of Patient Date

Name:________________ Age:________ Date:________________ Ref. Dr.: ________________

Please help us find out about you by filling out the "Patient" side of this form on pages 1-3. If you don't know the answer to one of the questions, ask your bed partner if he/she can answer it for you.

Please leave "Clinician" side blank.

**PATIENT** | **CLINICIAN**

**Why are you here to see a sleep specialist?**

________________

________________

**CC**

**HPI**

**Do you snore?**

☐ Yes ☐ No ☐ Don't know

If yes, is it loud?

☐ Yes ☐ No ☐ Don't know

How long ago did it start? ________________

Is it worsening?

☐ Yes ☐ No

In which position do you snore?

☐ Back only

☐ All positions

Is it worse on your back?

☐ Yes ☐ No

Do you snore if you fall asleep in a chair?

☐ Yes ☐ No

Does it disturb anyone?

☐ Yes ☐ No

Who? ________________

Has anyone ever noticed if you stop breathing in

☐ Yes ☐ No

Do you gasp or choke while you sleep?

☐ Yes ☐ No

**Do you suffer from either of the following in the**

☐ Dry mouth ☐ Headache

**Do you feel sleepy during the daytime?**

☐ Yes ☐ No ☐ Don't know

How many days per week? ________________

When did it start? ________________

Is it worsening?

☐ Yes ☐ No ☐ Don't know

**How likely are you to doze off or fall asleep**

Please use the following scale:

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

____ Sitting and reading

____ Watching television

____ Sitting inactive in a public place

____ While a passenger in a car without a break

____ Laying down to rest in the afternoon when circumstances permit

____ Sitting and talking to someone

____ Sitting quietly after a lunch without alcohol

____ In a car, while stopped in traffic for a few minutes

Epworth Score: ________________

| PATIENT | CLINICIAN |
|---|---|

Have you ever had a close call or accident when driving because of sleepiness?
☐ Yes ☐ No ☐ Don't know

Do you suffer from memory problems?
☐ Yes ☐ No

Are you more irritable lately?
☐ Yes ☐ No

Do you take any daytime naps?
☐ Yes ☐ No
How many per week? ________________
How long, on average, do they last? ______
Are the naps refreshing?
☐ Yes ☐ No

**Rate the severity of your sleepiness on a scale of 1 to 10. (1 being no sleepiness and 10 being very severe sleepiness)** ______________

**Do you ever experience restlessness or discomfort in your legs?**
☐ Yes ☐ No
When? ______________________________

What do you do to relieve it? ______________

How often does it occur? ________________

Does it interfere with sleep?
☐ Yes ☐ No

Do you move or kick your legs while sleeping?
☐ Yes ☐ No

Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience?
☐ Yes ☐ No

Have you ever felt paralyzed when you first wake up or when you are falling asleep?
☐ Yes ☐ No

Do you ever dream while you are falling asleep or during naps?
☐ Yes ☐ No

Do you walk or talk in your sleep?
☐ Yes ☐ No

Do you ever accidentally urinate in bed?
☐ Yes ☐ No

Do you have nightmares?
☐ Yes ☐ No

**Tell us about your sleep schedule:**

What is your bedtime? Start ____ End ____

How long does it take you to fall asleep? ______________

When do you wake up? ______________

Do you wake up in the middle of the night?
☐ Yes ☐ No
How many times per night? __________

Do you fall asleep again easily?
☐ Yes ☐ No

**Tell us about your daytime schedule.**

Work hours (if applicable) ______________________

If you don't work, how do you occupy your days?

______________________________

______________________________

______________________________

What do you do in the evening? ______________

Are you being treated now or have been treated for any illnesses? Please list them.

1 ______________________

2 ______________________

3 ______________________

4 ______________________

5 ______________________

## PAST FAMILY SOCIAL HISTORY

Past Med Hx

Have you ever had any operations? Any injuries?

1 ______________________

2 ______________________

3 ______________________

4 ______________________

5 ______________________

Past Surg Hx

Check if any close family member (parents, brothers and sisters, children) have:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heartburn

Family Hx

Are there any other health problems in your family?

______________________

## PATIENT

## CLINICIAN

Marital Status S M W D

Social Hx

With whom do you live? ______________________

What is your occupation? ______________________

What are your leisure activities? ______________________

______________________

What is your education level? ______________________

______________________

| | |
|---|---|
| Urinary problems: Frequency; infections; stones; bladder problems | Urinary |
| Men: Prostate problems; night-time urination | |
| Women: Abnormal menstrual periods; could you be pregnant? | |
| Joint pains swelling or redness; arthritis; back pain | Musculoskeletal |
| Muscle aches or tenderness; gout | |
| Rash, itching or other skin problems | Dermatological |
| Women: breast lumps; recent mammogram, pap smear and/or pelvic exam | Female Reproductive |
| Paralysis (even temporary); stroke; numbness; loss of balance | Neurological |
| Seizures; loss of memory; headaches | |
| Unusual thoughts; nervousness; crying or sadness; depression | Psychiatric |
| Suicide attempts | |
| Thyroid disorder; diabetes; excess thirst; hunger or urination | Endocrinology |
| Bleeding; easy bruising; risk factors for HIV; anemia; cancer | Hematological |

## Physical Exam

General Appearance ______________________________ Today's Wt ______________ Last Wt ______________ Ht ______________

Pulse ______________ BP: Sitting (Rt) __________ (Lt) __________ Standing (Rt) __________ (Lt) __________

Respirations ______________ Supine (Rt) __________ (Lt) __________ Pulse Oximetry __________(__________)

*All elements of Organ System are examined Normal*

| ☐ | N=NORMAL A=ABNORMAL D=DEFERRED | Description of Abnormal Findings |
|---|---|---|
| ☐ | 1) ***NOSE*** Mucosa _____ Turb _____ Septum _____ Sinuses _____ | |
| ☐ | 2) ***MOUTH*** Mucosa _____ Teeth _____ Gums _____ Posterior Pharynx _____ Palate - Hard _____ Soft _____ Base of Tongue _____ Tonsils _____ Uvula _____ Velopharynx _____ | |
| ☐ | 3) ***NECK*** Size _____ Masses _____ Symmetry _____ Thyroid _____ Crepitus _____ Thyroid _____ JVD _____ | |
| ☐ | 4) ***RESP*** Inspect _____ Symmetry _____ Effort _____ Percussion _____ Palpation _____ Ausc _____ | |
| ☐ | 5) ***HEART*** Apex _____ Heave _____ Thrill _____ Sounds _____ Murmur _____ Rub _____ | |
| ☐ | 6) ***ABDOMEN*** Masses/Tenderness _____ Liver _____ Spleen _____ Bowel Sounds _____ | |
| ☐ | 7) ***LYMPH*** Neck _____ Axillae _____ Groin _____ Other (Specify) _____ | |
| ☐ | 8) ***MUSCULOSKELETAL*** Gait _____ Station _____ Strength _____ Tone _____ Atrophy _____ Abnormal Movement _____ | |
| ☐ | 9) ***EXTREMETIES*** Varicosities ____ Edema _____ Pulses _____ Temp _____ Tenderness _____ Digits | |
| ☐ | 10) ***SKIN*** _____ (Describe scars, rashes, etc.) | |
| ☐ | 11) ***NEUROPHYCH*** Oriented _____ Mood _____ | |

Notes:

| New Patient | | Office/Hospital Consult |
|---|---|---|
| 99201 | 1-5 Bullet Points | 99241/99251 |
| 99202 | 6-11 Bullet Points | 99242/99252 |
| 99203 | 12-17 Bullent Points | 99243/99253 |
| 99204/ | All Items with Gray Border | 99244/99254 |
| 99205 | and 1 Item in each Non-Gray Border Box | 99245/99255 |

**DECISION MAKING**

- ☐ Lab (Date)
  - ☐ Thyroid Studies ______ ☐ Lytes ______ ☐ BUN/Cr ______
  - ☐ ABG ______
  - ☐ Other (Specify) ________________________

☐ Pulmonary Function Studies - Specify Date _______

☐ Other (List/Date) ____________________

**IMPRESSION:**

**PLAN:**

- ☐ F/U ________________
- ☐ Diagnostic NPSG
- ☐ Split NPSG/CPAP
- ☐ CPAP Titration
- ☐ MSLT
- ☐ Conditional MSLT
- ☐ Nocturnal Pulse Ox
- ☐ SNAP Test
- ☐ Lab ________________

☐ ENT Referral ____________________

☐ Dental Referral for OA _____________

______________________________________
Physician Signature