

Seep Solutions OF MISSISSIPPI

PATIENT NAN	/IE		Live Signature	
HOME PHON	E		OTHER	
PHARMACY_			PHONE	
ALLERGIES:				
DATE	MEDICATIONS	DOSAGE	FREQUENCY	STOP DATE



971 LAKELAND DRIVE, SUITE 752 JACKSON, MISSISSIPPI 39216

401 BAPTIST DRIVE, SUITE 401 MADISON, MISSISSIPPI 39110

OF MISSISSIPPI	PATIEN	NT REGISTRATION SHI	EET • PLEASE PRINT		DATE
PATIENT'S NAME	LAST		FIRST		MIDDLE
DATE OF BIRTH		GENDER	SOCIAL SECURITY	#	
MARITAL STATUS		DRIVERS LICENSE	∄#		1
MAILING					
ADDRESS	THE CONTROL OF THE CO	No.			
ZIP		СІТҮ		STATE	
PHONE	HOME	WO	₹K	CELLULAF	
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FINANCIALLY RESPO	DNSIBLE PARTY		DATE OF BIRTH		PHONE
ADDRESS		***			
PRIMARY INSURANC	IE PROVIDER				
ADDRESS CITY		074			ZIP
POLICY/ID NUMBER		STA			
INSUFED NAME		DATE OF B		GROUP NUMBI	
SECONDARY INSURA	ANGE PROVIDER	DAILOID	HILLE I	OUCIAL SECUI	111 E#
ADDRESS					
CITY		STAT	E		ZIP
POLICY/ID NUMBER				GROUP NUMBE	
INSURED NAME	Service of the servic	DATE OF B		SOCIAL SECUP	
REFERRAL INFORMA	TION REFERRED	BY:			
PERSONAL REPRESI	ENTATIVE(S) (List	any family member or	other person we may di	sclose your heal	Ith information to.)
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	Service of the servic				
The second of th	And the second s				*************************************



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		Dat	e
Method of Payment: MC/Visa	Check	Cash	• 1
STATEMENT TO PERMIT PAY	MENT OF MEDICA YSICIAN AND PATI		TIDER,
BENEFICIARY'S NAME:			
MEDICARE NUMBER:			
"I request that payment of authorized Me SOLUTIONS OF MISSISSIPPI for any any holder of medical information about nagents any information needed to determine	services furnished m ne to release to the He	e by that physician/providalth Care Financing Admir	ler. I authorized nistration and its

ease he he/she ease le	ave "Clinician" side blank.			
	PATTENT			
	Why are you here to see a sleep specialist?	CC	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
-	enore?	HPI		
	Yes □ No □ Don't know			
	If yes, is it loud? ☐ Yes ☐ No ☐ Don't know			*
	a les a la a bont 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			
	□ 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			
	□ Yes □ No			
	Do you gasp or choke while you sleep?			
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you f	Do you gasp or choke while you sleep? Yes			
you f	Do you gasp or choke while you sleep? Yes			

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? U Yes U No	
When?	
What do you do to relieve it?	
How often does it occur?	
now 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	
L TES LINO	
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	
Have been done to be to see to	
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	
Toll us shout your daybles as he dods	
Tell us about your daytime schedule.	
Work hours (if applicable)	
If you don't work how do you occurs your days?	
If you don't work, how do you occupy your days?	
What do you do in the evening?	

Have you ever had any operations? Any injuries? Have you ever had any operations? Any injuries? Past Surg Mx	them.		PASI PAMILI SULIAL MIS	SIURY
Are there any other health problems in your family? Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents, brothers and sisters, children) have: Check if any close family member (parents) have: Check if any close family have: Check if any clos		Past Med Hx		
Have you ever had any operations? Any injuries? Past Surg Hx 1 2 3 4 5 Check If any close family member (parents, brothers and sisters, children) have: Heart Problems High Blood Pressure Diabetes Concer Heartburn Are there any other health problems in your family? PAYTENT Marital Status S M W D Sodal Hx With whom do you live? What is your accupation? What are your leisure activities? What are your leisure activities? What is your accupation? What are your leisure activities? What is pour accupation? What are your leisure activities? What is pour accupation? What are your leisure activities? What is pour accupation? What are your leisure activities? What is pour accupation? What are your leisure activities? What is pour accupation? What is pour accupation? What are your leisure activities? What is pour accupation? What are your leisure activities? What is pour accupation? What are your leisure activities? What is pour accupation? What is pour accupation? What is pour accupation? What is pour accupation? Are there any other health problems in your family? It is pour accupation. Family Hx Clinicy Accupation. Family Hx Clinicy Hx Clinicy What is pour accupation in your family? It is pour accupation. Family Hx Clinicy Accupation. Family Hx Clinicy It is pour accupation. Family Hx Clinicy Accupation. Family Hx Clinicy Family Hx Clinicy It is pour accupation. Family Hx Clinicy Family Hx Clinicy Family Hx Clinicy Family Hx Clinicy	2			
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Check if any close family member (parents, brothers and sisters, family hx children) have:	5			
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Are there any other health problems in your family? PATIENT	□ Cancer			
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Dermatological Dermatological Female Reproductive Neurological Neurological Neurological Neurological Sis (even temporary); stroke; numbness; loss of balance sis; loss of memory; headaches al thoughts; nervousness; crying or sadness; depression attempts d disorder; diabetes; excess thirst; hunger or urination Dermatological Female Reproductive Neurological Psychiatric Psychiatric Endocrinology	ains swelling or redness; arthritis; back pain	Musculoskeletal		
Female Reproductive Female Reproductive Neurological Female Reproductive Neurological Female Reproductive Neurological Female Reproductive Neurological Psychiatric e attempts d disorder; diabetes; excess thirst; hunger or urination Female Reproductive Neurological Female Reproductive				
Neurological res; loss of memory; headaches res; loss of memory; headaches real thoughts; nervousness; crying or sadness; depression e attempts d disorder; diabetes; excess thirst; hunger or urination Neurological Psychiatric Endocrinology		Dermatological		•
es; loss of memory; headaches al thoughts; nervousness; crying or sadness; depression e attempts d disorder; diabetes; excess thirst; hunger or urination Endocrinology	n: breast lumps; recent mammogram, pap smear and/or pelvic exam	Female Reproductive		
es; loss of memory; headaches al thoughts; nervousness; crying or sadness; depression e attempts d disorder; diabetes; excess thirst; hunger or urination Endocrinology	sis (even temporary), stroke, numbbess, loss of balance	Maurological		
al thoughts; nervousness; crying or sadness; depression e attempts d disorder; diabetes; excess thirst; hunger or urination Endocrinology	es; loss of memory; headaches			
e attempts d disorder; diabetes; excess thirst; hunger or urination Endocrinology		Psychiatric		
d disorder; diabetes; excess thirst; hunger or urination Endocrinology		r sycinative		
		Endocripology		
Telliabolytal				
		macorogical		

Physics	al Exam				
201100111111111111111111111111111111111	Al Appearance	Today's Wt	Lact W/t	LIF	- Marian particular and the second and the second of the s
	BP: Sitting (Rt)				
	ations Supine (Rt)				
All elements	SERVICE SERVIC		and to the second se	The state of the s	
of Organ System are examined Normal					
	N=NORMAL A=ABNORMAL D:		Desci	iption of Abnormal Fir	dings
	1) <i>NOSE</i> Mucosa Turb Sinuses	Septum			
. П	2) MOUTH Mucosa Tee Posterior Pharynx Posterior Pharynx Base of Tongue Velopharynx	alate - Hard Soft Tonsils Uvula			:
	3) <u>NECK</u> Size Masses _ Thyroid Crepite JVD	Symmetry			
	4) <u>RESP</u> Inspect Symm Percussion Pal				
а	5) <u>HEART</u> Apex Heave Sounds Murmur				
٥	6) <u>ABDOMEN</u> Masses/Tender Spleen Bowel S	ness Liver			
	7) <u>LYMPH</u> Neck Axillae Other (Specify)				
ם	8) MUSCULOSKELETAL Gait Strength Tone Movement	Station Atrophy Abnormal			· .
	9) <u>EXTREMETIES</u> Varicosities Pulses Temp Te				

Notes:

11) NEUROPHYCH Oriented

10) <u>SKIN</u>

Mood

(Describe scars, rashes, etc.)

New Patient 99201 Office/Hospital Consult 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- 99245/99255 Gray Border Box

DECISION MAKING	
M 1-4 (D-4-)	
C Lab (Date)	C PUNICE
	O Lytes O BUN/Cr
O Other (Specify)	
B other (Specify)	
Pulmonary Function Studies	Specify Date
,	- Control of the Cont
☐ Other (List/Date)	
 	
IMPRESSION:	
PI-AM;	e en
	☐ F/U ☐ Diagnostic NPSG
	C) Split NPSG/CPAP
	G CPAP Titration
	O MSLT
	☐ Conditional MSLT
	☐ Nocturnal Pulse Ox
	C) SNAP Test
	and the state of t
	□ ENT Referral
	Dental Referral for OA
•	
	Physician Signature