SLEEP INSTITUTE of NEW ENGLAND

Accredited by the American Academy of Sleep Medicine

Sleep History Questionnaire

Patient Name:_____ Patient Phone: _____ DOB: _____ SSN: _____ Insurance: _____ Emergency Contact: _____ Emergency Contact #: _____	Ht:_____ Wt:_____ Neck size:_____	Primary Care name: _____ Pharmacy name: _____ Pharmacy location: _____

Allergies to Medications: Yes ( ) No ( ) if yes, explain: _____

Allergies to environmental agents: Yes ( ) No ( ) if yes, explain: _____

Do you have any of the following medical problems?

Yes ( ) No ( ) Heart disease if yes, explain: _____

Yes ( ) No ( ) Diabetes if yes, explain: _____

Yes ( ) No ( ) High blood pressure if yes, explain: _____

Yes ( ) No ( ) Cancer if yes, explain: _____

Yes ( ) No ( ) Thyroid disease if yes, explain: _____

Yes ( ) No ( ) Lung problems if yes, explain: _____

Yes ( ) No ( ) Kidney problems if yes, explain: _____

Yes ( ) No ( ) Depression if yes, explain: _____

Yes ( ) No ( ) Anxiety if yes, explain: _____

Yes ( ) No ( ) Insomnia if yes, explain: _____

Yes ( ) No ( ) Chronic pain if yes, explain: _____

Yes ( ) No ( ) Other_____ if yes, explain: _____

Have you ever had a thyroid blood test? Yes ( ) No ( ) if yes, how long ago? _____

Prior Surgeries (including oral or nasal surgeries): _____

Are you currently using a CPAP or BiPAP machine? Yes ( ) No ( )

If yes, for how long & what are your current pressures?

_____

Where was your previous sleep study? _____

List your current medications: prescriptions, over the counter and herbals (with dosage):

Sleep Hygiene

Time to bed: _____ Time out of bed: _____

Do you stay in bed the entire night? If not, why? _____

How long does it take you to fall asleep? _____

If more than 30 minutes, why? _____

How many hours of sleep do you get each night? _____

Sleep History **Please completely fill in the circles**

Please select all that apply.

O snoring O nasal congestion O sinus problems

O heartburn O allergy problems O tiredness while driving

O falling asleep while driving O daytime sleepiness/fatigue O falling asleep at work

O falling asleep in meetings O falling asleep in public places O un-refreshed sleep

O sleep walking O falling asleep with laughter/crying O feeling paralyzed upon awakening

O witnessed periods of not breathing or gasping for air O difficulty falling asleep

O teeth grinding O leg cramps O morning headaches

O acting out dreams O watches TV in bed O lights on all night

O TV on all night O leg movements with sleep O urge to move or rub legs

O hallucinations with morning awakenings O leg swelling

O ankle swelling O awakenings at night O daytime naps

Family History

Did your mother, father, brothers, sisters or children have any of the following?

O heart disease O arrhythmias O thyroid problems O lung problems O psychiatric disorders

O sudden death O obesity O sleep disorders O diabetes O stroke

O high blood pressure

Social History

Marital Status	O married	O single	O divorced/Sep	O widowed	O partnered
Employment status	O full time	O part time	O unemployed	O student	O stay at home parent
	O retired				
Children at home	O Yes	O No			

Smoking history

O current smoker	O former smoker	O never smoked	O current every day smoker
O current some days smoker	O smoker but current status unknown		O unknown if ever smoked

Social History

Alcohol:	O never	O social	O daily	O more than 2 drinks daily
Recreational drugs:	O never used	O former user	O current user	
Exercise	O none	O 1-2 days/wk	O 3 or more days/wk	
Caffeine	O none	O 1-2 per day	O 2-5 per day	O more than 5 per day

Review of Systems

O weight change	O night sweats	O fatigue	O weakness	O fever
O trouble breathing through nose		O sinus problems	O sore throat	O change in voice
O night time congestion		O nosebleeds	O runny/stuffy nose	O sinus infections
O ear fullness	O nasal allergies	O heat intolerance	O excessive sweating	O cold intolerance
O hot flashes	O chronic cough	O wheezing	O pain with breathing	O shortness of breath
O chest discomfort	O shortness of breath lying down		O palpitations	O swelling in ankles
O indigestion	O abdominal pain	O change in bowel habits		O joint swelling
O joint stiffness	O muscle pain	O chronic pain	O leg cramps	O headache
O tingling/numbness	O seizures	O memory problems	O falls	O dizziness
O gait abnormality	O high stress/tension	O attention deficit	O anxiety	O depression
O eating disorder	O nighttime urination	O sexual dysfunction	O	

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The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to felling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = No Chance of Dosing

1= Slight Chance of Dosing

2 = Moderate Chance of Dozing

3 = High Chance of Dozing

Situation	Chance of Dozing
Sitting and reading	
Watching television	
Sitting inactive in a public place	
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 to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

SLEEP INSTITUTE of NEW ENGLAND

FINANCIAL POLICY FOR THE SLEEP INSTITUTE OF NEW ENGLAND

We are committed to providing you with the best possible care. Our professional fees can be discussed with you at any time. Your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our financial policy, fees or what your responsibility is. All patients must complete this form before seeing the provider.

- *Co-pays are due at the time of the visit. We accept cash, check, Money Order, and all major credit cards*
- *Returned check fee of $75.00 is due upon receipt of a Patient Statement.*
- *We accept most major insurance plans to include Medicare, Aetna, Anthem, Cigna, Harvard Pilgrim, Martin's Point, Tufts, and United, among others. We do not accept any Medicaid plans.*
- *Balances after insurance determination for co-pays, deductibles and coinsurance are due upon receipt of a Patient Statement. Patient payment plans will be considered before the service is provided. Balances over 60 days without arrangements made with the Sleep Institute Financial Office are subject to an outside collection effort*
- *Office visit no-show or cancellations within 24 hours are subject to a $75.00 cancellation fee.*
- *Overnight sleep studies no-show or cancellations within 24 hours are subject to a $200.00 cancellation fee.*

Insurance Policy

- We will assist you to receive maximum benefits but we do not guarantee any information we are given from your insurance company. We may verify your insurance benefits and submit your claim to your insurance carrier as a courtesy to you.
- You are ultimately responsible for knowing your insurance benefits to include any deductible, coinsurance and co-pays for diagnostic procedures, which includes sleep studies. If you are not familiar with your coverage, we highly recommend that you contact your insurance directly prior to any appointments. Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract.
- *The account balance is your responsibility whether your insurance company pays or not,* as *pre-estimate of benefits is never a guarantee of payment by your insurance.*
- Prior to your appointment, please let us know of any insurance changes you may have had since your last visit.

PATIENT INITIALS: _____

Referral Policy

Many insurance plans require a referral and or authorization for treatment from your Primary Care Physician prior to receiving services. All non-covered services are the financial responsibility of the patient.

If you have a dispute over a balance because your insurance company did not pay in accordance with any kind of pre-authorization, please understand that this dispute is not with our office but is with your insurance company.

This balance is due in full on receipt of a Patient Statement from the Sleep Institute of New England which will be sent to you after insurance company determination of benefits. We will continue any proceedings needed to collect this balance.

PATIENT INITIALS: _____

No Insurance Policy

The Sleep Institute of New England has a patient discount for patients without insurance. Ask the staff for details prior to your appointment if you do not have insurance. Patients without insurance must pay the full amount at the time of service, unless a payment arrangement is approved prior to an appointed service.

By signing below, I authorize that I have read the entire financial policy and I understand and agree to abide by the above policy.

Print Name _____ Date _____

Signature_____

SLEEP INSTITUTE of NEW ENGLAND

PATIENT CONSENT FORM

I hereby give my consent for **Sleep Institute of New England** to use and disclose protected health information about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Sleep Institute of New England describes such uses and disclosures more completely.)

By signing this consent, **Sleep Institute of New England**, which utilizes an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that, may contain health related information or healthcare management advice at the telephone number(s) that you have provided, in reference to any items that assist the practice in carrying out treatment, payment and health care operations such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Sleep Institute of New England** may decline to provide treatment to me.

PATIENT INITIALS: _____

Consent to Examination and Treatment:

I hereby consent to allow the physician and physician extenders (Nurse Practitioner or Physician Assistant) of Sleep Institute of New England to examine and treat me in connection with my visits to Sleep Institute of New England. **I also understand that my follow up appointments will be with a physician extender.**

PATIENT INITIALS: _____

Financial Responsibility:

I understand that I am financially responsible to Sleep Institute of New England, PLLC for charges not covered by my insurance carrier. Payment for services are due at time of service unless prior arrangements have been made. There will be a $75.00 fee for returned checks.

PATIENT INITIALS: _____

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable

SLEEP INSTITUTE of NEW ENGLAND

Anti-Discrimination Notice

The Sleep Institute of New England (SINE) does not discriminate on the basis of disability, race, color, creed, gender, age, sexual orientation, or national origin, in admission to, access to or operation of its programs, services, activities or its hiring or employment practices.

E-Mail Address:

Preferred language

☐ English

☐ Other _____

Ethnicity

☐ Hispanic or Latino

☐ NOT Hispanic or Latino

☐ Declined to specify

Race

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Caucasian

☐ Native Hawaiian or Other Pacific Islander

☐ Other

☐ Declined to specify

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MEDICAL RECORDS REQUEST

Patient's name: _____ DOB: _____

Patients address: _____

Records to be obtained from:

_____
_____
_____
_____
_____
_____

Records to be sent to:

Sleep Institute of New England

1 Little River Road

Kingston, NH 03848

Phone: 603-347-8810 Fax: 603- 347-8811

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, sleep studies, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____

Patient's Signature **Date**: