WESTMORELAND SLEEP MEDICINE
PATIENT REGISTRATION

Patient Name ______________________ Patient Address ______________________

PHONE Home ______________ Work ______________ Cell ______________

Birthdate ______________ Age ________ Soc. Sec. # ______________

Email ______________ Referring Doctor ______________ Primary Doctor ______________

INSURANCE: Primary ______________ Secondary ______________

Subscriber Name ______________ Birthdate ______________ Soc. Sec. # ______________ Relationship to Patient ______________

PRIVACY/HIPAA NOTICE & CONSENT

Westmoreland Sleep Medicine (WSM) has my permission to use and disclose protected health information (PHI) about me for treatment, payment, and health care operations purposes. I have received WSM's Privacy Notice describing their disclosure practices and how I can access my PHI and exercise other rights concerning my PHI. WSM reserves the right to amend their Privacy practices and to have any amendments effective for all PHI, including information created or obtained by WSM prior to the date of the amendment. I am aware I can obtain any revisions or amendments by requesting so in writing. I HAVE REVIEWED THE CURRENT PRIVACY NOTICE.

The following are the individuals that I permit to receive information regarding my care.

______________ ______________ ______________

ASSIGNMENT OF BENEFITS

I certify that I (or my dependant) have insurance coverage as listed above and assign directly to WSM all insurance benefits and payments that I am eligible for under my insurance for services rendered. I understand that I am responsible for all charges, whether covered by insurance or not. I also hereby authorize WSM to release all information necessary to third parties to secure the payment of claims. I authorize the submission of this assignment to insurers and third parties as part of the claim(s) submission and payment collections.

Responsible Party Signature ______________ Date ______________ Relationship to Patient ______________

MEDICARE AUTHORIZATION

I request that payment of Medicare benefits be made either to me or on my behalf to WSM for any and all services furnished to me by WSM. I authorize any holder of PHI to release as needed to the Centers for Medicare and Medicaid Services and its agents for benefits determination or payment for rendered services. If "other health insurance" is indicated in Item 9 of the HCFA 1500 form, or on any other claim form/electronically submitted claim, I am also authorizing release of PHI to the insurer or agent shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and deductibles are based upon the determination of the Medicare carrier.

Beneficiary Signature ______________ *Date* ______________

WESTMORELAND SLEEP MEDICINE

Patient Name: ______________________________ **Date:** _________________

Age: _____ **Sex:** M F **Referring Physician**:_____________________________

SLEEP HISTORY

1. What time do you go to bed? _____:_____
2. How long does it take you to fall asleep? _____ minutes
3. Does your bedtime vary a lot? Yes No
    a. If yes, please specify: ____
4. Do you have difficulty sleeping during the night? Yes No
5. If yes, you have difficulty sleeping during the night:
    a. How often do you usually wake up at night? _______times
    b. How long are these awakenings? _______ minutes
    c. Is your sleep disturbed by noise/ choking sensation/ heartburn/ breathlessness/ pain/ having to urinate/ feeling hungry/ restless legs/ leg cramps/ palpitations/ other_________________?
    d. Have you ever taken prescription or over-the-counter sleeping pills? Yes No
        i. If so, which one(s)? ______________________________
        ii. Was it of help? Yes No
    e. What other treatments have you tried to help with your sleep? ___________________
6. Have you ever been told that while you sleep you:
    a. Snore? Yes No
    b. Quit breathing? Yes No
    c. Thrash about/ have excessive leg jerking movements? Yes No
    d. Walk? Yes No
    e. Grind your teeth? Yes No
7. Do you experience night sweats? Yes No
8. What time do you usually wake up? _____:_____
9. When you wake up, do you:
    a. Feel refreshed? Yes No
    b. Experience headaches? Yes No
10. Are you experiencing:
    a. Tiredness? Yes No
    b. Memory lapses? Yes No
    c. Difficulty concentrating? Yes No
    d. Body aches/ joint pain? Yes No

Patient Name: ______________________________

11. What is your collar/ neck size? _____inches
12. Employed? Yes No; Occupation: ______________________________
13. Shift work? Yes No; If yes, explain: ______________________________

CURRENT MEDICATIONS (including those used for sleeping):

MEDICATION	**SPECIFY**
Prescription (Dose and frequency):	
Non-prescription:	
Oxygen therapy (How much, continuous/ nightly, name of home care company)	

Have you ever used any of the following?

	No	**Yes**	**If yes, how much?**
Caffeine (coffee, tea, soda, etc.)			
Alcohol			
Cigarettes			
Street drugs (Marijuana, "uppers", "downers", narcotics, hallucinogens, cocaine)			
Other			

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EPWORTH SLEEPINESS SCALE

Patient Name: ______________________________ **Date:** ________________

Age: _______ **Sex** (circle one): Male Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Please use the following scale to choose the most appropriate number in each situation.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public space (e.g., a theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon should circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total (numerical value):	