First Name: **Last Name:**

Date of Birth:

Gender: Male ☐ Female ☐

Marital Status: Never Married ☐ Married ☐ Divorced ☐ Widowed ☐

Primary Physician:
Phone Number:

Main Sleep Concern / Problem: (Check all that apply)

Sleepiness / Feeling tired ☐
Breathing stops while sleeping ☐
Difficulty staying asleep ☐
Difficulty falling asleep ☐
Bed partner asking you to seek help ☐
Other Reason ☐

How long have you experienced sleep problems?

Please describe any past professional evaluations or treatments for your sleep problems. (Please include what was and was not helpful)

Have you had a sleep study before? (If so, please provide where and when it was performed)

Please check any of the following activities you do in bed?

Read ☐ Watch TV ☐ Eat ☐ Talk on the phone ☐ Listen to music ☐
Argue ☐ Worry ☐ Watch the clock ☐ Use a device ☐

Does your bed feel comfortable to you? Yes ☐ No ☐

Is your bedroom comfortable, dark, and quiet? Yes ☐ No ☐

How many pillows do you sleep with under your head?

What is your occupation?

Who is your employer?

Do you work nights or shift work? Yes ☐ No ☐

What type of exercise do you do? (if any)

How often do you exercise?

Sleep Symptoms

When trying to sleep how often do you experience the following:

	Daily	Weekly	Monthly	Rarely	Never
Difficulty *falling* asleep?	☐	☐	☐	☐	☐
Trouble *staying* asleep?	☐	☐	☐	☐	☐
Repeated awakenings?	☐	☐	☐	☐	☐
Waking up *too early?*	☐	☐	☐	☐	☐
Snoring or trouble breathing?	☐	☐	☐	☐	☐
Choking or gasping for air?	☐	☐	☐	☐	☐
Morning headaches?	☐	☐	☐	☐	☐
Dry mouth?	☐	☐	☐	☐	☐
Have others said you stop breathing at night?	☐	☐	☐	☐	☐
Irresistible desire to move legs?	☐	☐	☐	☐	☐
Kept awake because of bed partner?	☐	☐	☐	☐	☐

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling 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:

Sitting and reading

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Watching TV

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Sitting inactive in a public place (theater, meeting, etc.)

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

As a passenger in a car for an hour without a break

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Lying down to rest in the afternoon when circumstances permit

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Sitting and talking to someone

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Sitting quietly after lunch *without* alcohol

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

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

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Medical Review of Systems

Headaches ☐
Vision problems ☐
Nasal congestion ☐
Difficulty swallowing ☐
Chest pain ☐
Heart palpitations ☐
Wheezing ☐
Erectile dysfunction ☐

Shortness of breath ☐
Abdomen discomfort ☐
Diarrhea ☐
Constipation ☐
Bloody stools ☐
Urinary frequency ☐
Incontinence ☐

Muscle pain ☐
Joint pain ☐
Skin rash ☐
Feeling depressed ☐
Feeling anxious ☐
Heart burn ☐
Coughing ☐

General Medical History

Do you currently have or have you ever been diagnosed with: (check all that apply)

High blood pressure ☐
Heart disease ☐
Heart attack ☐
Kidney disease ☐
Neurologic disease ☐
Stroke ☐
Anxiety / Panic disorder ☐

Elevated cholesterol ☐
Lung disease ☐
Heart arrhythmia ☐
Head trauma / Concussion ☐
Seizure disorder ☐
Thyroid disease ☐
Fibromyalgia ☐
Drug abuse / addiction ☐

Diabetes ☐
Liver disease ☐
Stomach reflux (GERD) ☐
Immune disorder ☐
Arthritis ☐
Depression ☐
Alcoholism ☐

Other Medical Conditions:

Allergies to Medications:

Medications:

Medication Name	Dosage	Frequency

Many commonly used substances can affect sleep. Please describe your use of the following over the last month.

If you drink **Caffeinated** beverages (including coffee, tea, sodas etc.) please list your daily consumption.

If you drink **Alcoholic** beverages (including wine, beer, liquor) please list your daily consumption.

If you use **Tobacco** products (include cigarettes, cigars, snuff, chew, etc) list your daily use.

Family Medical History

Please list relatives (parents, siblings, children etc.) who snore, or have sleep apnea:

Please list family medical history such as heart disease, stroke, diabetes, cancer:

Financial Responsibility & Office Policy

Thank you for choosing SleepMed Solutions for your medical care. We are committed to providing you with quality health care, and we appreciate your commitment to adhere to this agreement.

INSURANCE Your medical insurance is a contract between you and your insurance company. SleepMed Solutions is not a party to that contract. We will file insurance claims on your behalf, as a courtesy. In order for your claims to be processed timely and accurately, you must present a current insurance card and state issued photo ID at each visit. If you arrive without your card, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. SleepMed Solutions' policy is to have Social Security numbers from all patients to file insurance claims. This helps protect both the patient and SleepMed Solutions from insurance fraud. All information provided to us is part of your confidential health record and is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CLAIM SUBMISSION If your insurance company requires you to supply information to them for processing of a claim, you must comply with their request in a timely manner. If your insurance company has not processed a claim on your behalf within 90 days of submission due to information that you have not provided, the balance will be transferred to your responsibility. If a payment is subsequently received for that claim, you may request reimbursement from Raleigh Durham Medical Group Billing Department at 866.557.2612, or you may choose to leave the amount as a credit on your account.

MEDICARE Medicare deductibles and co-insurances are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and, if applicable, to your secondary insurance carrier. Please notify the front desk staff if you have recently changed Medicare plans. Third-party claims are the responsibility of the patient.

NON-CONTRACTED INSURANCE PLANS Payment is required at time of service.

CO-PAYMENTS/DEDUCTIBLES/PAYMENTS Payment is required at the time of service. We currently accept Cash, Personal Checks, Visa, MasterCard, and Discover. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office PRIOR to your appointment to discuss payment arrangements. There will be a $35.00 service charge for all returned checks.

SELF-PAY Uninsured patients are classified as Self-Pay. We can provide an estimate of our fees prior to services in the office. This is only an estimate; actual charges may be higher or lower.

MINORS Parents and guardians are responsible for payments for their dependents at the time of service. Patients between the ages of 16 and 18 can be seen without a parent or guardian present, as long as parent or guardian is reachable by phone.

MISSED APPOINTMENTS Unless canceled at least 24 hours in advance, a charge will be accessed for missed appointments. This fee is NOT covered by your insurance plan and is solely your responsibility.

LATE ARRIVAL If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule.

FORMS Forms requiring medical review and physician signature will be completed within 7-10 business days, and may be subject to a $15 fee. Please make sure to allow plenty of time for completion. Emergencies will be handled on a case-by-case basis.

PATIENT CONFIDENTIALITY In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the SleepMed Solutions Notice of Privacy Practices is available to all patients in the office or online.

I have read, understand, and agree to the above **Financial and Office Policies**. I authorize SleepMed Solutions to furnish medical information regarding my examinations and treatments to my insurance carriers, and assign all benefits payable to SleepMed Solutions to be used towards the payment of my account:

Patient Printed Name/Date of Birth _____

Patient Signature/Date _____

HIPAA Authorization & Disclosure

I authorize the use and/or disclosure of my protected health information as described in Section B below. I further understand that this authorization is voluntary, and that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

SECTION A: PATIENT INFORMATION

Patient Name _____

Patient Date of Birth _____

Patient Phone _____

Patient Address _____

Patient City/State/ZIP _____

SECTION B: DISCLOSURE OF PROTECTED HEALTH INFORMATION

With whom may SleepMed Solutions discuss or release your protected health information, either in writing or verbally?

Name/Relationship _____ Name/Relationship _____

Name/Relationship _____ Name/Relationship _____

What do you wish for SleepMed Solutions to discuss with your authorized family/friends?

- ☐ All medical information and/or payment information
- ☐ Only specific information (please describe) _____

_____

SECTION C: EXPIRATION OF AUTHORIZATION

This authorization will expire:

- ☐ On this date: _____
- ☐ Upon the patient's death

HIPAA (continued)

RIGHT TO REVOKE I understand that I may revoke this authorization an any time by giving written notice of my revocation to the SleepMed Solutions office listed at the bottom of this form. I understand that revocation of this authorization will not affect any action Sleep Med Solutions took in reliance of this authorization prior to receiving my written notice of revocation.

INABILITY TO CONDITION TREATMENT I understand that SleepMed Solutions may not treat my condition upon my refusal to sign this authorization.

VOICE MAIL AUTHORIZATION SleepMed Solutions may leave medical information regarding your care or appointments on an answering machine or voice mail, if you so choose.

☐ Yes, you may leave messages at this phone number: _____

OFFICIAL AUTHORIZATION

☐ I acknowledge that I have been made aware of SleepMed Solutions' Notice of Privacy Practices, and I have had full opportunity to read and consider the contents of SleepMed Solutions' Notice of Privacy Practices.

Patient Printed Name _____

Patient Signature/Date _____

Patient's Authorized Representative Printed Name _____

Patient's Authorized Representative Signature/Date _____

Relationship to Patient _____

It is your right to refuse to sign this authorization. You are also entitled to a copy of this completed form.

2729 Horse Pen Creek Road, Suite 103 Greensboro, NC 27410 336.907.7773 phone 336.907.7902 fax

STOP-BANG Sleep Apnea Questionnaire

yes	no	
☐	☐	**SNORING:** Do you snore loudly?
☐	☐	**TIRED:** Do you often feel tired, fatigued, or sleepy during the daytime?
☐	☐	**OBSERVED APNEA:** Has anyone witnessed you stop breathing during your sleep?
☐	☐	**PRESSURE:** Do you have or are you being treated for high blood pressure or hypertension?
☐	☐	**BMI (Body Mass Index):** Do you weigh more for your height than is shown on the table below?
☐	☐	**AGE:** Are you over 50 years old?
☐	☐	**NECK SIZE:** Is your neck size greater than 16 inches?
☐	☐	**GENDER:** Are you a male?

HEIGHT IN FEET AND INCHES

4′10″	4′11″	5′0″	5′1″	5′2″	5′3″	5′4″	5′5″	5′6″	5′7″	5′8″	5′9″	5′10″	5′11″	6′0″	6′1″	6′2″	6′3″	6′4″	6′5″
167	173	179	185	191	197	204	210	216	223	230	237	243	250	258	265	272	279	287	295

WEIGHT IN POUNDS

SCORE: Total number of "yes" answers ☐

INTERPRETATION: 0-2: Low risk of Obstructed Sleep Apnea

3-8: High risk of Obstructed Sleep Apnea

Patient Printed Name _____

Patient Signature/Date _____

Chung et.al, "STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea", Anesthesiology. 2008; 108(5):812-821

Effective Date November 2021

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