Ed Charnock, MD, FAASM
Jack Gardner, MD, FCCP

Accredited by the American Academy of Sleep Medicine

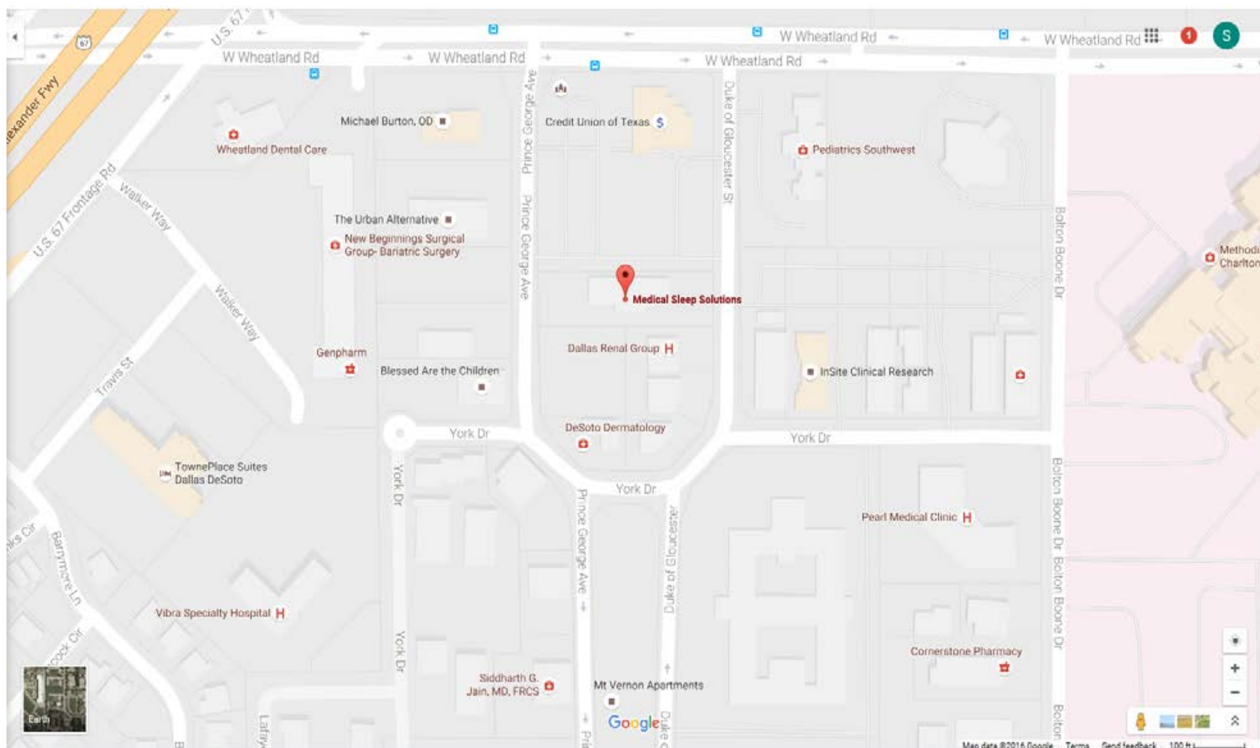
<u>Desoto New Patient</u>

Fax: 972-780-4796   Phone: 972-709-7190

1001 Robbie Mince Way Desoto, TX. 75115

Your appointment has been scheduled at the Desoto/Duncanville location. Here are the directions upon your arrival.

- **The Desoto office is located off of Wheatland Rd., one block West of the Charlton Methodist Hospital.**
- **From Wheatland, you will need to turn South onto Prince George.**
- **Our office is the second building on the left side, directly behind the Credit Union of Texas Bank.**



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Welcome to Medical Sleep Solutions

Date: ____

Patient: ____

Appointment Date & Time: ____

All new patients are required to arrive 30 minutes prior to their scheduled appointment time. Otherwise, you may be rescheduled.

You are scheduled on the above date to be seen in our office. Please complete the attached paperwork and bring it with you to your appointment. Also, please be sure to bring your current insurance card and a photo ID. If a referral is required by your insurance, please bring that as well. You will be responsible for any co-pays at the time of your appointment as required by your insurance plan.

We require a 24-hour cancellation/reschedule notice. Not showing up for an appointment without notice will result in a $30.00 fee that is payable before you are able to reschedule your next appointment. Multiple or consecutive no-shows may result in dismissal from our practice. If you need to cancel or change your appointment, please call our office 24 hours in advance.

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Patient Information Form

Name (Last) ______________________ (First) ____________________ (MI) ________ Age______

Street Address ____ Apt # _________ Sex F / M

City _________________________________ State _____________________ Zip ____________

Hm Phone (______) _______________________ Wk Phone (______) _______________________

Cell Phone (______) _____________________ Email Address _____________________________

Date of Birth __________________________ Social Security Number _______________________

Employer ______________________________ Occupation _________________________________

Referring Physician ____________________________ Phone (______) ______________________

Referring Physician Address ____

Spouse's Name ____

Spouse's Social Security # _______________________Spouse's Date of Birth __________________

Spouse's Employer ___________________________ Spouse's Work # (______) ________________

Emergency Contact ______________________________ Phone # (______) ___________________

PATIENT INSURANCE INFORMATION

Primary Insurance Company ______________________________ Group # ____________________

Policy Holder: SELF __ SPOUSE __ PARENT __ Insurance ID # _________________ DOB: _______

Policy Holder:
Name ___________________________________ Social Security # ___________________________

Claims Mailing Address ___________________________________ Phone # ____________________

Secondary Insurance Company __________________________________ Group # _____________

Policy Holder: SELF __ SPOUSE __ PARENT __ Insurance ID # ______________________________

Policy Holder Name ____

Policy Holder Social Security # ____________________ Policy Holder Date of Birth _______________

Claims Mailing Address ________________________________ Phone # ______________________

I hereby assign all medical and/or surgical benefits to Medical Sleep Solutions. I understand that I am financially responsible for all charges, whether paid or not paid by my insurance company. I also authorize the physician to release any medical information and records, if needed, to assist reimbursement from the insurance company. I authorize Medial Sleep Solutions to provide medical treatment.

Patient Signature ____ Date _____________________
Responsible Party Signature ________________________________ Date _____________________

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General Medical Information

Name: ___________________________________ **Date:** ________________ **Age:** __________

YEAR ILLNESSES

_________ ( ) Heart Trouble: (Coronary Artery Disease __) (Heart Attack __) (Heart Failure__)
(Heart Murmur__) (Pacemaker __) (Defibrillator __) Other________________________
_________ ( ) Heart Rhythm: (Arrhythmia __) (Atrial Fibrillation __)
_________ ( ) High Blood Pressure _________ ( ) High Cholesterol
_________ ( ) Brain: (Stroke __) (TIA __) (Dementia __) (Seizure Disorder __) (Migraine Headaches __)
_________ ( ) GI Disease: (GERD/Heartburn __) (Stomach Ulcer__) (Duodenal Ulcer __)
(Diverticulitis__)
_________ ( ) Diabetes (High Blood Sugar) (Taking Insulin __ / Not Taking Insulin __)
_________ ( ) Thyroid: (Low Thyroid __) (High Thyroid __)
_________ ( ) Liver Disease: (Hepatitis__) (A__) (B__) (Cirrhosis__) Other ______________________
_________ ( ) Kidney: (Chronic Kidney Disease __) (Hemodialysis __) (Peritoneal Dialysis __)
(Stones__)
_________ ( ) Lung Disease: (Emphysema__) (COPD__) (Chronic Bronchitis__)
(Use Oxygen at __ lpm) (Asthma__)
_________ ( ) Sleep Apnea: Using PAP machine __ / Using Mouthpiece __ / Untreated __)
_________ ( ) Blood Disorders: (Anemia__) (Leukemia__) (Bleeding Disorder: Type ______________)
Other__________________________
_________ ( ) Eye Disease: (Glaucoma__) Other____________________
_________ ( ) Arthritis: (Degenerative__) (Rheumatoid__) (Gout__) Other_____________
_________ ( ) Cancer, Type____________________________________
_________ ( ) Psychological: (Depression__) (Anxiety __) (Bipolar __) (PTSD __) (Schizophrenia __)
Other ____
_________ ( ) Chronic Pain: (Cervical/Neck __) (Lumbar/Low Back __)
_________ ( ) Other Major Illness ____

YEAR	**SURGERIES**	**YEAR**	**SURGERIES**
_________	( ) Tonsillectomy	_________	( ) Gallbladder
_________	( ) Nasal Septum	_________	( ) Appendectomy
_________	( ) UPPP (Palate Surgery for Sleep Apnea)	_________	( ) Prostate
_________	( ) Thyroid: (Removed __) (RAI Ablation __)	_________	( ) Vasectomy
_________	( ) Hysterectomy (Total__) (Partial__)	_________	( ) Hernia
_________	( ) Coronary Artery Stents	_________	( ) Cervical (Neck)
_________	( ) Coronary Artery Bypass Surgery	_________	( ) Lumbar (Low Back)
_________	( ) Heart Valve Surgery	_________	( ) Bariatric (Weight Loss)
_________	( ) Artery Bypass Surgery / Stents in Legs		
_________	( ) Other ____________________________________		

MAJOR INJURIES
( ) Auto Accidents or Trauma: ____
HOSPITALIZATIONS (last 3 months): ____

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Please circle symptoms you currently have:

Constitutional

Recent weight change

Fever

Headaches

Eyes

Eye Disease

Wear contacts/glasses

Blurred Vision

Respiratory

Chronic coughs

Shortness of breath

Wheezing

Genitourinary

Frequent urination

Blood in urine

Impotence

Ear/Nose/Throat/Mouth

Hearing loss

Earache

Nose bleeds

Cardiovascular

Chest pain

Palpitations

Swelling in extremities

Musculoskeletal

Joint pain

Weakness of muscles

Back pain

Gastrointestinal

Loss of appetite

Nausea / Vomiting

Abdominal pain

Endocrine

Hormone problems

Excessive Thirst

Skin becoming dryer

Neurological

Frequent headaches

Dizziness

Numbness

Psychiatric

Memory loss

Nervousness

Depression

Integumentary

Rash / itching

Change in hair / nails

Breast pain / lump

Hematologic / Lymphatic

Slow to heal after cuts

Anemia

Enlarged glands

____

Signature **Date**

Which Doctor or Dentist referred you to us?

____

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FAMILY MEDICAL HISTORY

MOTHER: ( ) Alive & Well ( ) Alive but suffers with:____
( ) Deceased / Cause:____ Age of Death: _____________

FATHER: ( ) Alive & Well ( ) Alive but suffers with:____
( ) Deceased / Cause:____ Age of Death: _____________

Health Conditions of extended family members (siblings, children, grandparents) include:

( ) Stroke
( ) High Blood Pressure
( ) Heart Attack
( ) Congestive Heart Failure
( ) Diabetes
( ) High Cholesterol
( ) Cancer: Type _______________

SOCIAL HISTORY

1. Married ___, Separated ___, Divorced ___, Widow-Widower ___, Single ___
2. Work status: Working ____ Retired ____ Disabled ____ Commercial Driver ____
3. I drink alcohol: None ____ Occasionally ____ Frequently ____ Daily ____ Weekends Only ____
Describe generally the type of drink (beer, wine, liquor) and how much you consume when you drink.
____
4. I smoke: None ____ Cigarettes ____ Pipe ____ Cigars ____
Smoker for how long? About 1Yr ____ Several years ____ Many Years ____ Most of my adult life ____
Currently smoke ____ packs per day. I quit smoking. If so, how long ago? ______________
5. Chew tobacco: Yes ____ No ____ If yes, how many years? _________

MEDICATIONS (Names & Dosages)

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____
11.____
12.____
13.____
14.____
15.____
16.____
17.____
18.____
19.____
20.____

ALLERGIES **REACTION**

( ) Penicillin ______________________________
( ) Sulfa ______________________________
( ) Keflex ______________________________
( ) Codeine ______________________________
( ) Other ______________________________
( ) Other ______________________________
( ) Other ______________________________
( ) ***NONE***

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Epworth Sleepiness Scale

Print Name: ________________________ ( ) Male ( ) Female DOB:______________

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

Even if you haven't done some of these activities recently, think about how they would have affected you.

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3= high chance of dozing

***It is important that you circle a number (0 to 3) on each question.**

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactively in a public place (e.g. a theater or meeting)	0 1 2 3
As a passenger in a car for about an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking	0 1 2 3
Sitting quietly after lunch (without alcohol)	0 1 2 3
In a car while stopped in traffic	0 1 2 3
	Total _____________

I understand I should only drive when fully alert. I should NOT drive, operate machinery, or perform any hazardous task when drowsy or sleepy.

Patient Signature: ____________________________________ Date: _____________________

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Date: _______________

Dr. Gardner and his staff have my permission to discuss my medical condition, medical treatment and medical billing information with:

______________________________	______________________	______________________
Name	Relationship	Phone Number
______________________________	______________________	______________________
Name	Relationship	Phone Number
______________________________	______________________	______________________
Name	Relationship	Phone Number

____

Patients Signature

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for these purposes.

TREATMENT
We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT
Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS
We may need to use information about you to review out treatment procedures and business activity. Information may be used for certification, compliance and licensing activities. I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____

Relationship to Patient: ____

Signature: ____

Date:____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________ **Initials/Clinician:** __________

Reason: ____

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Sleep Study Results

At the time of your evaluation for sleep apnea, our clinicians will review various treatment options and considerations. Final treatment recommendations will be based on the severity of the sleep apnea and your other health conditions.

When our physicians interpret your sleep study, they make a treatment recommendation for you. If you have moderately severe or severe sleep apnea, then CPAP (device with hose and mask) is generally recommended for you. If you have mild or low moderate sleep apnea, then you have a number of treatment options that may work well for you.

If CPAP is the clear treatment recommendation after interpretation of your sleep study, you will receive a phone call from our staff to schedule an overnight sleep study to adjust the CPAP device properly to treat your sleep apnea. **We do not require for you to follow-up after the initial sleep study to review test results when CPAP is recommended.**

We are sensitive to the fact that your time is valuable. We do not want you to incur an additional expense and/or unnecessary office visits. We will review all the test results and recommendations with you when your testing is complete.

If CPAP is not the clear treatment recommendation after interpretation of your sleep study, you will receive a call to schedule an office visit to review sleep study results and discuss your treatment options as well as the pros and cons of each option. **Our clinicians do not review sleep study results with you by phone.** This is a complex discussion and speaking with patients by phone regarding specific details of sleep studies sometimes causes confusion and may lead to poor care.

Our desire is for you to feel comfortable and well informed at every stage of your evaluation. If at any time you become confused or unclear regarding your evaluation, **please know that we encourage you to schedule a follow-up visit to clarify any concerns before proceeding with further testing.**

______________________________ __________________________

Patient Name Date