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

Accredited by the American Academy of Sleep Medicine

Welcome to Medical Sleep Solutions

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 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 appropriate notice will result in a $50.00 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.**

Our Location:

Address: 2460 N I-35 Professional Plaza 1 - Suite 250 Waxahachie, TX 75165 (Corner of Hwy 287 & I-35 E North). Enter through the right – hand side doors facing I-35. We are on the second floor down the left hallway, second door on the left, suite 250.

If you have any questions regarding this appointment, please do not hesitate to call us. (972) 923-4480

Thank You

Medical Sleep Solutions Waxahachie,

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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 _____

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_____
_____ ( ) Phychological: (Depression__) (Anxiety __) (Bipolar __) (PTSD __) (Schizophrenia __) Other _____
_____ ( ) Chronic Pain: (Cervical/Neck __) (Lumbar/Low Back __)
_____ ( ) Other Major Illness _____

YEAR SURGERIES

_____ ( ) Tonsillectomy
_____ ( ) Nasal Septum
_____ ( ) UPPP (Palate Surgery for Sleep Apnea)
_____ ( ) Thyroid: (Removed __) (RAI Ablation __)
_____ ( ) Hysterectomy (Total__) (Partial__)
_____ ( ) Coronary Artery Stents
_____ ( ) Coronary Artery Bypass Surgery
_____ ( ) Heart Valve Surgery
_____ ( ) Artery Bypass Surgery / Stents in Legs
_____ ( ) Other _____

YEAR SURGERIES

_____ ( ) Gallbladder
_____ ( ) Appendectomy
_____ ( ) Prostate
_____ ( ) Vasectomy
_____ ( ) Hernia
_____ ( ) Cervical (Neck)
_____ ( ) Lumbar (Low Back)
_____ ( ) Bariatric (Weight Loss)

MAJOR INJURIES

( ) Auto Accidents or Trauma: _____

HOSPITALIZATIONS (last 3 months): _____

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 1 year ____ 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***	

Please circle symptoms you currently have:

Constitutional	Eyes	Respiratory
Recent weight change	Eye Disease	Chronic coughs
Fever	Wear contacts/glasses	Shortness of breath
Headaches	Blurred Vision	Wheezing

Genitourinary	Ear/Nose/Throat/Mouth	Cardiovascular
Frequent urination	Hearing loss	Chest pain
Blood in urine	Earache	Palpitations
Sexual difficulty	Nose bleeds	Swelling in extremities

Musculoskeletal	Gastrointestinal	Endocrine
Joint pain	Loss of appetite	Hormone problems
Weakness of muscles	Nausea / Vomiting	Excessive Thirst
Back pain	Abdominal pain	Skin becoming dryer

Neurological	Psychiatric	Integumentary
Frequent headaches	Memory loss	Rash / itching
Dizziness	Nervousness	Change in hair / nails
Numbness	Depression	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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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: _____

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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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: _____