Tampa Bay Pulmonary Associates, P.A.

Tampa Bay Sleep Center

Ashok K. Modh, M.D., F.C.C.P
Naishadh K. Mandaliya, M.D., F.C.C.P.
Jerges J. Cardona, M. D.
Nirav B. Patel, M. D.

DATE_____

NAME_____Soc. Sec. #_____
Last First Initial

Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Sex: M F Birthdate_____ Single Married Divorced Widowed Separated

Spouses Name_____Cell Phone_____

Emergency Contact Name Not Living in Your

Home_____Relationship_____

Phone_____

Who may we thank for referring you?_____

Race_____Ethnicity_____Primary Language_____

****

Your Employer_____Occupation_____

Address_____

****

Insurance Information

Primary company name_____**ID#**_____

Secondary company name_____**ID#**_____

Subscriber Name_____**Soc. Sec. #**_____

Subscriber Birthdate_____**Relationship to Patient**_____

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Please present this form, your driver's license and all insurance I. D. cards to the receptionist. Please read the following authorization and sign the form where indicated.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED WHETHER OR NOT PAID BY THE ABOVE STATED INSURANCE COMPANY(IES). I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY AND ALL INFORMATION NECESSARY TO SECURE REIMBURSEMENT FROM ANY INSURANCE COMPANY TO WHICH I HAVE SUBSCRIBED. I HEREBY AUTHORIZE DIRECT PAYMENT TO ***TAMPA BAY PULMONARY ASSOCIATES, P.A.*** FOR ANY SERVICES FURNISHED ME BY THE PHYSICIANS. I AGREE AND UNDERSTAND THAT I MAY BE CHARDED 1.5% INTEREST RATE PER MONTH ON ANY UNPAID BALANCE AND THAT I AM RESPONSIBLE FOR ANY COSTS INCURRED IN COLLECTION OF SAID BALANCE SHOULD THAT BECOME NECESSARY. I HAVE READ AND UNDERSTAND THE ABOVE AND AGREE TO COMPLY.

PATIENT SIGNATURE_____**DATE**_____

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NAME_____ DATE OF BIRTH_____

PHONE_____ CELL_____

PHARMACY_____ PHARMACY PHONE_____

ALLERGIES_____

MEDICATIONS THAT YOU TAKE NOW

NAME OF MEDICINE	DOSAGE	TIME THAT YOU TAKE THE MEDICINE

SIGNATURE_____DATE_____

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

AS PART OF YOUR HEALTHCARE, THIS PRACTICE ORIGINATES AND MAINTAINS PAPER AND/OR ELECTRONIC RECORDS DESCRIBING YOUR HEALTH HISTORY, SYMPTOMS, EXAMINATIONS AND TEST RESULTS, DIAGNOSES, TREATMENT AND ANY PLANS FOR FUTURE CARE OR TREATMENT. THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING YOUR CARE AND TREATMENT
- A MEANS TO COMMUNICATE WITH HEALTH PROFESSIONALS WHO CONTRIBUTE TO YOUR CARE
- A SOURCE FOR APPLYING YOUR DIAGNOSIS AND TREATMENT INFORMATION FOR PAYMENT PURPOSES

AS PART OF YOUR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS, IT MAY BECOME NECESSARY TO DISCLOSE HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS (REFERRALS OR CONSULTATIONS), LABORATORIES, INSURANCE COMPANIES FOR PAYMENT, AND/OR OTHER INDIVIDUALS OR AGENCIES AS PERMITTED OR REQUIRED BY STATE OR FEDERAL LAW.

ACKNOWLEDGEMENT

I HAVE BEEN PROVIDED WITH A COPY AND THE OPPORTUNITY TO READ THE ***"PATIENT HEALTH INFORMATION PRIVACY PRACTICES"*** THAT PROVIDES A MORE COMPLETE DESCRIPTION OF HEALTH INFORMATION USES AND DISCLOSURES. I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS:

- THE RIGHT TO READ THE ***"PATIENT HEALTH INFORMATION PRIVACY PRACTICES"*** PRIOR TO SIGNING THIS CONSENT.
- THE RIGHT TO REQUEST A COPY OF THE "***PATIENT HEALTH INFORMATION PRIVACY PRACTICES"*** FOR MY OWN USE.
- THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

RESTRICTIONS

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

_____

_____

I FULLY UNDERSTAND, ACKNOWLEDGE AND ACCEPT THIS CONSENT.

SIGNATURE_____DATE_____

PRINT NAME_____

IF NOT PATIENT, STATE RELATIONSHIP_____

FOR OFFICE USE ONLY

CONSENT FORM REVIEWED BY _____DATE_____

PATIENT REFUSED TO SIGN_____REASON_____

_____

_____**RESTRICTIONS WERE ADDED BY THE PATIENT (SEE RESTRICTIONS ABOVE)**

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ **Your sex**: ❑ Male ❑ Female

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

This refers to your usual way of life in recent times.

Even if you haven't 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 = 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 place (e.g. a theatre or a meeting)	
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 the traffic	
Total	

Score:	
0-10	Normal range
10-12	Borderline
12-24	Abnormal

SLEEP QUESTIONNAIRE

PATIENT INFORMATION

NAME_____DATE_____

DATE OF BIRTH_____SEX_____RACE_____

HEIGHT_____WEIGHT_____NECK SIZE_____

FAMILY DOCTOR_____REFERRING DOCTOR_____

IF YOUR DOCTOR DID NOT SEND YOU TO US, HOW DID YOU FIND OUT ABOUT OUR PRACTICE?

SLEEP PROBLEMS (PLEASE CHECK ALL THAT APPLY)

____SNORING ____GASPING/CHOCKING/PAUSES IN BREATHING WHEN YOU SLEEP

____DIFFICULTY FALLING ASLEEP ____DIFFICULTY STAYING ASLEEP

____TIRED/SLEEPY DURING THE DAY ____UNUSUAL BEHAVIOR DURING SLEEP (TALKING/WALKING, KICKING, ETC.

____MORNING HEADACHES _____OTHER_____

PLEASE DESCRIBE YOUR SLEEP-RELATED PROBLEMS_____

GENERAL HABITS

1. DESCRIBE YOUR WORK SCHEDULE._____
2. IF YOU WORK SHIFT WORK, DO YOU KEEP THE SAME SCHEDULE ON OFF DAYS?_____
3. HOW MUCH COFFEE, TEA OR COLA DO YOU DRINK PER DAY?_____
4. DO YOU SMOKE?_____HOW MUCH?_____
5. DO YOU DRINK ALCOHOLIC BEVERAGES?_____HOW MUCH & WHEN?_____
6. DO YOU EXERCISE REGULARLY?_____HOW MUCH AND WHEN?_____

SLEEP HABITS

1. WHAT TIME DO YOU GO TO BED ON WORK DAYS?_____NON-WORK DAYS?_____
2. WHAT TIME DO YOU GET UP ON WORK DAYS?_____NON-WORK DAYS?_____
3. HOW MUCH TIME DO YOU THINK THAT YOU ACTUALLY SLEEP?_____

4. DO YOU TAKE NAPS?_____WHEN & FOR HOW LONG?_____

5. DO YOU FEEL RESTED AFTER TAKING A NAP?_____

6. DO YOU HAVE A BED PARTNER THAT OBSERVES YOUR SLEEP?_____IF SO, WHAT HAVE THEY OBSERVED?_____

7. HOW LONG DOES IT TAKE YOU TO FALL ASLEEP?_____

8. DO YOU TAKE MEDICATION OR ALCOHOL TO HELP YOU SLEEP?_____HOW MUCH AND HOW OFTEN?_____

9. DO YOU EVER HAVE A STONG URGE TO MOVE YOUR LEGS AND/OR FEET?_____

10. IF YOU ANSWERED YES TO QUESTION #8, DOES WALKING OR STRETCHING HELP?_____

11. DO YOU NOTICE ANY OF THE FOLLOWING WHEN TRYING TO FALL ASLEEP?

- ANXIETY, WORRY OR DISTURBING THOUGHTS ____YES ____NO
- DIFFICULTY BREATHING ____YES ____NO
- PAIN ____YES ____NO
- SEEING/HEARING THINGS THAT DO NOT EXIST ____YES ____NO

12. DO YOU EXHIBIT ANY OF THE FOLLOWING:

- SNORING ____YES ____NO
- STOP BREATHING OR GASPING FOR AIR ____YES ____NO
- GRINDING YOUR TEETH ____YES ____NO
- SLEEPWALKING, TALKING, EATING ____YES ____NO
- KICKING OR TWITCHING OF LEGS/FEET ____YES ____NO
- ACTING OUR YOUR DREAMS ____YES ____NO
- WAKING UP IN THE MIDDLE OF NIGHT ____YES ____NO
- GOING TO BATHROOM EXCESSIVELY AT NIGHT ____YES ____NO
- IRRITIBILITY ____YES ____NO
- MEMORY LOSS ____YES ____NO
- DIFFICULTY CONCENTRATING ____YES ____NO
- DRY MOUTH WHEN YOU WAKE UP ____YES ____NO
- NIGHT SWEATS ____YES ____NO
- TOSSING AND TURNING ____YES ____NO

13. HOW DO YOU FEEL WHEN YOU WAKE UP IN THE MORNING?_____

14. HOW OFTEN DOES YOUR SLEEP PROBLEM EFFECT YOUR LIFE?_____

15. HAVE YOU EVER FELT UNABLE TO MOVE FOR A SHORT TIME WHEN YOU WAKE UP?_____

16. WHEN YOU ARE LAUGHING, SURPRISED, OR ANGRY DO YOU FEEL WEAKNESS?_____

HEALTH AND FAMILY HISTORY

1. DOES ANYONE IN YOUR FAMILY HAVE A SLEEP DISORDER (SLEEP APNEA, NARCOLEPSY, RESTLESS LEG SYNDROME/PERIODIC LIMB MOVEMENT DISORDER, INSOMNIA)?_____IF SO, WHO AND WHICH DISORDER DO THEY HAVE?_____

2. HAVE YOU EVER HAD A SIGNIFICANT HEAD INJURY, TIA OR STROKE?_____

3. DID YOU HAVE ANY SLEEP PROBLEMS AS A CHILD?_____IF SO, DESCRIBE_____

4. HAVE YOU FELT DEPRESSED, ANXIOUS OR WORRIED MORE THAN USUAL IN THE PAST MONTH?_____IF SO, DESCRIBE_____

5. PLEASE LIST CURRENT HEALTH PROBLEMS THAT YOU HAVE.

6. PLEASE LIST ANY SURGERIES.

7. WOMEN ONLY – ARE YOU PRE- OR POST-MENOPAUSAL?_____

8. HAVE YOU ALREADY BEEN DIAGNOSED WITH A SLEEP DISORDER?_____
WHEN AND WHERE?_____

9. ARE YOU ON ANY TREATMENT OR THERAPY (INCL. CPAP) NOW?_____IF SO, PLEASE DESCRIBE._____