Salinas Valley Medical Clinic

SLEEP/WAKE

Dear Patient,

Thank you for choosing Salinas Valley Medical Clinic-Sleep/Wake for your health care needs. We are committed to the goal of providing the highest quality care possible for the evaluation and treatment for your sleep related problems.

We realize that the high cost of quality medical care is a concern of all recipients of health care today. In light of these concerns, we feel it's important that we provide a clear explanation of service(s) that will be billed and encourage you to discuss any questions or concerns you may have with our business office. It is hoped these explanations will help to eliminate any confusion or misunderstanding regarding billed services.

Salinas Valley Medical Clinic-Sleep/Wake is affiliated with the Physician providing your consultation. Service(s) that may be billed by your doctor for the evaluation for your sleep related problem may consist of:

1) Professional fees associated with initial consultation or follow up office visits.
2) Sleep laboratory test/procedures, including interpretation.

Services providing for sleep disorder evaluations are generally covered by most insurance policies. It is the policy of Salinas Valley Medical Clinic-Sleep/Wake to request payment for the estimated deductible and/or copayment amount at the time that services are provided. We will also submit a claim for insurance payment, however please be aware that on occasion some insurance companies may select certain services that they cover at a lesser percentage. In most cases, we will provide reasonable assistance in challenging seemingly inappropriate insurance allowance but it should be understood that all charges are ultimately the responsibility of the patient.

We wish to thank you for the opportunity to serve your medical needs and encourage you to contact our billing office at (831) 649-1000 with any questions or concerns you may have.

I acknowledge that I have read and understand the billing policy and information described above.

_____ _____

Patient, Guardian, or Legal Representative Date

_____ _____

Witness Date

**MAZHAR JAVAID, MD**
Diplomate, ABIM and ABSM in sleep
**NAEEM RANA, MD**
Diplomate, ABIM
**JOHN ROPER, MD**
Diplomate, ABSM and ABSM in sleep
**KHALID RAUF, MD**
Sleep Medicine

Salinas Valley Medical Clinic

SLEEP / WAKE

120 Wilgart Way | Salinas | CA 93901

T 831.424.1400 | F 831.424.1441

## Patient Demographic Sheet

Pt Age _____ Date of Birth: ____/____/____ Date of Visit: ____/____/____

Patient Name: _____ (Last) _____ (First) _____ (Initial) _____ (Suffix)

Address: _____ (Street) _____ (City, State, Zip)

Phone: _____ (Home) _____ (Work/Cell) Preferred # to call: _____

Email Address: _____

Sex: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widow

Ethnicity: ❒ White ❒ African American ❒ Hispanic ❒ Asian/Pacific Islander ❒ American Indian/Alaskan Native ❒ Other _____

SSN: ___-___-___ Employer Name: _____ Occupation: _____

How did you hear about us?

Referred By: ❒ Doctor _____ (Name) _____ (Specialty) _____ (Address) _____ (Phone)

❒ TV Ad ❒ Radio Ad ❒ Newspaper ❒ Website ❒ Friend ❒ Other (Please Specify) _____

*For Staff Use Only*: UPIN: _____ NPI: _____

Reason for Visit: _____

Have you been a patient in our office before? ❒ Yes ❒ No

Have you ever participated in a Sleep Study? ❒ Yes ❒ No When? _____ Where? _____

Sleep Complaint: _____ Duration of Problem: _____

Do you snore? ❒ Yes ❒ No If yes, for how long? _____ Years

Height: _____ feet _____ inches Weight: _____ lbs. General Health: _____

Health Insurance: ❒ Yes ❒ No

Primary Insurance: _____ (Name of Primary Policyholder) _____ (Date of Birth) _____ (SSN)

_____ (Insurance Co. Name) _____ (Member/Group Number) _____ (Relationship)

Secondary Insurance: _____ (Name of Primary Policyholder) _____ (Date of Birth) _____ (SSN)

_____ (Insurance Co. Name) _____ (Member/Group Number) _____ (Relationship)

In Case of Emergency Contact: _____ (Name) _____ (Phone Number) _____ (Relationship to Patient)

X _____

Patient's Signature Date

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## CONSENT FOR TREATMENT

I, _____, hereby grant permission to the medical doctors and personnel of Salinas Valley Medical Clinic-Sleep/Wake to provide medical care and treatment, as deemed professionally/medically advisable.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Witness Signature Date

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Salinas Valley Medical Clinic-Sleep/Wake to obtain any and all records regarding my current medical conditions, for the purpose of reviewing and examination. I further authorize Salinas Valley Medical Clinic-Sleep/Wake to release my records to any other physician or hospital involved in my medical care or to my insurance company for claims payment. Should records include mention of mental health, alcohol/drug abuse, sickle cell anemia or HIV, AIDS, ARC or hepatitis, I still authorize their release. This authorization shall remain in full force and effect for one year unless consent is cancelled by written notice to Salinas Valley Medical Clinic-Sleep/Wake.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Witness Signature Date

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient: _____ Acct. #: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area.

Signed: _____ Date: _____

**Declined:**

Reason for denial: _____

Employee signature: _____ Date: _____

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Patient Name: _____

Account Number: _____

Date of Birth: _____

I hereby authorize Salinas Valley Medical Clinic-Sleep/Wake to disclose my medical/financial information to the following person/s:

| | |
|---|---|
| Name: | Name: |
| Relationship: | Relationship: |
| Birth date: | Birth date: |
| Restrictions: (i.e. medical info only, financial info only) | Restrictions: (i.e. medical info only, financial info only) |

TO OUR PATIENTS:

This authorization will remain in effect until you revoke or modify it in writing. Any persons not listed above will not be given access to your personal information unless you personally call and give verbal consent.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient: _____ Date: _____

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Name: _____ Referred By: _____

Date of Birth: _____ Date: _____

Race: _____ Age: _____ Sex: ❒ M ❒ F

Marital Status: ❒ S ❒ M ❒ D ❒ W

Allergies: _____

## Medical History:

**Physical History: Ever diagnosed with? (Check All That Apply)**

- ❒ Asthma
- ❒ Arthritis
- ❒ Cancer
- ❒ Emphysema
- ❒ Meningitis
- ❒ Stroke
- ❒ Parkinson's
- ❒ Seizures
- ❒ Narcolepsy
- ❒ Alzheimer's
- ❒ Dementia
- ❒ Spinal Injury
- ❒ GERD (Acid Reflux)
- ❒ Thyroid Disease
- ❒ Anemia
- ❒ High Blood Pressure
- ❒ Sleep Apnea
- ❒ Heart Attack
- ❒ Heart Failure
- ❒ Head Injury
- ❒ Irregular heart beat
- ❒ MVA (Motor Vehicle Accident)
- ❒ Fibromyalgia
- ❒ Chronic Fatigue Syndrome
- ❒ Encephalitis
- ❒ Menopause
- ❒ B12 Deficiency
- ❒ Psychological/Behavioral (See Box Below)
- ❒ Diabetes
- ❒ Obesity
- ❒ High Cholesterol
- ❒ Other _____

**Behavioral History: (Check All That Apply)**

**Are there any recent events that would cause you to feel any of the following?**

- ❒ Anxious
- ❒ Depressed
- ❒ Angry
- ❒ Excitable
- ❒ Fearful
- ❒ Out of Balance (Emotionally)
- ❒ Other (Describe) _____

**Have you ever experienced the following events?**

- ❒ Marital Separation
- ❒ Divorce
- ❒ Death of a Spouse

**Have you ever been diagnosed with an Emotional/Behavioral Disorder?**

- ❒ Yes
- ❒ No

***If you wish to provide additional information, you may do so on the next page, using the section marked "Comments"***

## Lifestyle Habits:

| | | | |
|---|---|---|---|
| Do you drink alcohol? | ❒ Yes | ❒ No | How much _____ How long _____ |
| Drink Caffeine/Soft Drinks? | ❒ Yes | ❒ No | How many cups _____ |
| Do you smoke? | ❒ Yes | ❒ No | Pk/D _____ Yrs _____ |
| Had issues with substance abuse? | ❒ Yes | ❒ No | |

**Hospitalizations:**

| Name of Hospital: | Year of Procedure: | Reason for Procedure: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Family History:**

If family member is living, leave last column blank. For Medical Problems, please list any the family member may have had, even if the problem *DID NOT* attribute to the cause of death.

| Family History | Age | Medical Problems | Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) | | | |
| Sister(s) | | | |
| Children/Boy | | | |
| Children/Girl | | | |

**Sleep Hygiene:**

**Sleep Environment:**

| | | | |
|---|---|---|---|
| Temperature in Bedroom? | ❒ Too high | ❒ Too low | ❒ Just right |
| Lighting? | ❒ Dark | ❒ Too much light | |
| Interruptions? (Noise, Etc.) | ❒ Yes | ❒ No | |
| Partner's Sleep Habits? | ❒ Normal | ❒ Disruptive | |
| Does Partner? | ❒ Snore | ❒ Kick Legs | |

**Chief Complaint: (Check all that apply)**

- ❒ Can't fall asleep
- ❒ I fall asleep ok, but wake up many times
- ❒ I get up too early
- ❒ I sleep too long
- ❒ I get up un-refreshed
- ❒ I snore loudly
- ❒ I stop breathing during sleep

**Comments:** _____

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**History:**

Normal bedtime during work week: _____

Normal wake up time: _____

Weekend bedtime: _____

Weekend wake up time: _____

Are you a shift worker? ☐ Yes ☐ No

Is your sleep refreshing? ☐ Yes ☐ No

Are you worried at bedtime? ☐ Yes ☐ No

Do you:

Watch T.V. in the bedroom? ☐ Yes ☐ No

Read in the bedroom? ☐ Yes ☐ No

Eat at bedtime? ☐ Yes ☐ No

**Snoring:**

Do you snore? ☐ Yes ☐ No

Duration _____ Position _____

Do you sleep alone? ☐ Yes ☐ No

**Do you suffer from any of the following:**
(Check all that apply)

Dry mouth? ☐ Yes ☐ No

Sore throat? ☐ Yes ☐ No

AM headaches? ☐ Yes ☐ No

Weight gain or loss? ☐ Yes ☐ No

Enuresis? ☐ Yes ☐ No

Sweat during sleep? ☐ Yes ☐ No

**Arousal:**

Number of times you awake during the night: _____

Time you spend out of bed: _____

**During sleep, do you suffer from any of the following:**
(Check all that apply)

Gasping? ☐ Yes ☐ No

Talking? ☐ Yes ☐ No

Walking? ☐ Yes ☐ No

Shortness of breath? ☐ Yes ☐ No

Heart palpitations? ☐ Yes ☐ No

Panic? ☐ Yes ☐ No

Do you stop breathing? ☐ Yes ☐ No

Erectile problems? ☐ Yes ☐ No

Leg jerk? ☐ Yes ☐ No

Leg cramps? ☐ Yes ☐ No

Crawling sensation in legs? ☐ Yes ☐ No

Does moving your legs improve discomfort for short time? ☐ Yes ☐ No

Wake up choking? ☐ Yes ☐ No

Have nightmares? ☐ Yes ☐ No

**Do you fall asleep while:**

Having a conversation? ☐ Yes ☐ No

Watching T.V.? ☐ Yes ☐ No

Reading? ☐ Yes ☐ No

Driving? ☐ Yes ☐ No

At work? ☐ Yes ☐ No

**Daytime functioning - Do you ever experience:**

Memory loss? ☐ Yes ☐ No

Lack of conversation? ☐ Yes ☐ No

Feel too tired? ☐ Yes ☐ No

Sleep during the day? ☐ Yes ☐ No

Irritability? ☐ Yes ☐ No

Take naps? ☐ Yes ☐ No

If yes, how often? ☐ Yes ☐ No

How long? _____

Are they refreshing? ☐ Yes ☐ No

Vivid dreams when about to sleep or wake up? ☐ Yes ☐ No

Seeing bright lights when you are about to sleep or wake? ☐ Yes ☐ No

Does anger or excitement ever cause you to feel your body go limp? ☐ Yes ☐ No

Have sleep paralysis? ☐ Yes ☐ No

Have a sleep attack? ☐ Yes ☐ No

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***Please do not write below this line.***

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Height _____ Weight _____

BMI _____ ESSS _____

BP _____ Resp _____

P _____ Neck size _____

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Mallampati | ☐ | ☐ | ☐ | ☐ |
| Tonsils | ☐ | ☐ | ☐ | ☐ |
| Mandible | ☐ | ☐ | ☐ | ☐ |
| Maxillae | ☐ | ☐ | ☐ | ☐ |
| Submentle | ☐ | ☐ | ☐ | ☐ |

Macroglossia ☐ Yes ☐ No

Teeth marks ☐ Yes ☐ No

Dream enactment ☐ Yes ☐ No

Violent behavior ☐ Yes ☐ No

Patient Name: _____ DOB: _____

# EPWORTH SLEEPINESS SCALE

In the last 30 days, how likely are you to doze off or fall asleep in these situations (in contrast to feeling just tired)?

| Please check only one box per row. | High Chance of Dozing 3 | Moderate Chance of Dozing 2 | Slight Chance of Dozing 1 | Would Never Doze 0 |
|---|---|---|---|---|
| 1. Sitting and reading | | | | |
| 2. Watching TV | | | | |
| 3. Sitting inactive in a public place (e.g. theater, meeting) | | | | |
| 4. As a passenger in a car for an hour without a break | | | | |
| 5. Lying down to rest in the afternoon | | | | |
| 6. Sitting and talking to someone | | | | |
| 7. Sitting quietly after lunch (when you've had no alcohol) | | | | |
| 8. In a car while stopped for a few minutes in traffic | | | | |
| TOTAL SCORE | | | | |

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# MEDICATION SHEET

| Date Started | Medication | Date Stopped |
|---|---|---|
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