ATLAS SLEEP DIAGNOSTICS
Navigating you to better sleep

NEW PATIENT FORM

APT DATE: APT TIME:

PERSONAL INFORMATION

PATIENT NAME:			DOB:
GENDER: ☐ MALE ☐ FEMALE	SOCIAL SECURITY #:		
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE #:		CELL PHONE #:	
EMAIL:			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
REFERRING PROVIDER:		PRIMARY PROVIDER:	

REASON FOR VIST TO SLEEP CLINIC

Please indicate below the main symptoms or reasons for which you seek a consultation with the sleep clinic:

☐ SNORING ☐ TIRED / SLEEPY DURING DAY ☐ LEG CRAMPS DURING DAY / NIGHT

☐ DIFFICULTY FALLING TO SLEEP ☐ MORNING HEADACHES ☐ LIMB MOVEMENTS DURING SLEEP

☐ DIFFICULTY STAYING ASLEEP ☐ UNUSUAL BEHAVIORS DURING SLEEP ☐ GASPING / CHOKING DURING SLEEP

☐ OTHER:

EMERGENCY CONTACT

NAME:	RELATIONSHIP:	CONTACT #:

SOCIAL INFORMATION

RACE:

☐ CAUCASIAN ☐ AFRICAN AMERICAN ☐ ASIAN / PACIFIC ISLANDER ☐ DECLINE ☐ OTHER:

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER:
CHILDREN AT HOME: ☐ YES ☐ NO *If Yes How Many:*	EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ OTHER:
OCCUPATION:	EMPLOYMENT SHIFT: ☐ DAY ☐ SWING ☐ NIGHT ☐ OTHER:
CAFFEINE CONSUMPTION: ☐ YES ☐ NO *If Yes How Many Cups Per Day:*	ALCOHOL CONSUMPTION: ☐ YES ☐ NO *If Yes How Many Drinks Per Week:*
TOBACCO USE: ☐ YES ☐ PREVIOUS SMOKER ☐ NON-SMOKER # of years: _____ # packs per day: _____ ☐ ORAL TABBACCO USE	SUBSTANCE USE: ☐ YES ☐ NO *If Yes, Frequency:*

NEW PATIENT FORM

MEDICATION ALLERGIES	
MEDICATION NAME:	REACTION:

CURRENT MEDICATIONS		
MEDICATION:	DOSE:	FREQUENCY:

PAST MEDICAL HISTORY

Please list any surgeries or hospitalizations:

Please select any diagnoses that apply to you now or in the past:

☐ ALLERGIES/NASAL CONGESTION/SINUSITUS ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ ARTHRITIS

☐ HEART DISEASE (ANGINA / HEART ATTACK) ☐ MIGRAINE HEADACHES ☐ DEPRESSION ☐ KIDNEY DISEASE

☐ CONGESTIVE HEART FAILURE ☐ ATRIAL FIBRILLATION ☐ ANXIETY ☐ HYPOTHYROIDISM

☐ SEIZURES / EPILEPSY ☐ EMPHYSEMA/COPD ☐ DIABETES ☐ HYPERTHYROIDISM

☐ NEUROMUSCULAR DISORDER ☐ OTHER:

FAMILY HISTORY

Does anyone in your immediate family (mother, father, siblings, children) have a history of any of the following:

☐ ALZHEIMERS / DEMENTIA ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ DIABETES ☐ SLEEP APNEA

☐ SEIZURE DISORDER ☐ DEPRESSION ☐ ANXIETY ☐ OTHER MOOD DISORDERS

☐ CANCER:

☐ OTHER:

REVIEW OF SYSTEMS	
Please select any symptoms that have occurred in the past 30 days. If Yes, please briefly explain.	
CONSTITUTIONAL:	
NIGHT SWEATS	□ NO □ YES
FEVER / CHILLS	□ NO □ YES
EYES:	
BLURRED VISION	□ NO □ YES
EYE PAIN	□ NO □ YES
DRY EYES	□ NO □ YES
EARS / NOSE / THROAT:	
EAR PAIN	□ NO □ YES
TINNITUS (EAR RINGING)	□ NO □ YES
HOARSENESS	□ NO □ YES
CARDIOVASCULAR:	
CHEST PAIN	□ NO □ YES
PALPATATIONS	□ NO □ YES
LEG/FEET SWELLING	□ NO □ YES
RESPIRATORY:	
COUGH	□ NO □ YES
SHORTNESS OF BREATH	□ NO □ YES
GASTROENTEROLOGY:	
ABDOMINAL PAIN	□ NO □ YES
ACID REFULX	□ NO □ YES
CONSTIPATION	□ NO □ YES
URINARY:	
PAINFUL URINATION	□ NO □ YES
URINARY URGENCY	□ NO □ YES
FREQUENT NIGHTIME URINATION	□ NO □ YES
MUSCULOSKELETAL:	
JOINT PAIN	□ NO □ YES
MUSCLE CRAMPS / PAIN	□ NO □ YES
NEUROLOGY:	
DIZZINESS	□ NO □ YES
NUMBNESS	□ NO □ YES
WEAKNESS	□ NO □ YES
ENDOCRINE:	
EXCESSIVE THIRST OR HUNGER	□ NO □ YES
PSYCHOLOGY:	
ANXIETY	□ NO □ YES
DEPRESSION	□ NO □ YES

NEW PATIENT FORM

SLEEP HISTORY

1. Have you been evaluated in a sleep center or taken home a sleep test? ☐ YES ☐ NO
2. Have you ever used any of the following Positive Airway Pressure Devices? ☐ CPAP ☐ APAP ☐ BIPAP ☐ ASV
3. Do you currently use supplemental oxygen at home? ☐ YES ☐ NO

TYPICAL BED TIME:	TIME TO FALL ASLEEP:	NIGHTIME AWAKENINGS:	TIME TO FALL BACK TO SLEEP:
TYPICAL WAKEUP TIME:	# OF NAPS PER DAY:	LENGTH OF NAPS:	
HOW MANY HOURS OF SLEEP DO YOU GET:		HOW MANY HOURS DO YOU SPEND IN BED?	

Do you feel your knees buckle or your arms feel weak or jaw drop when you are happy or sad?	☐ NO ☐ YES, *EXPLAIN:*
Do you experience vivid dream-like episodes or scenes upon awakening or falling asleep that you can't tell whether they are real or not?	☐ NO ☐ YES, *EXPLAIN:*
Do you ever feel paralyzed upon waking or falling asleep?	☐ NO ☐ YES, *EXPLAIN:*
Do you have a history of head trauma or loss of consciousness?	☐ NO ☐ YES, *EXPLAIN:*
Do you have leg cramps at bedtime?	☐ NO ☐ YES, *EXPLAIN:*
Do you experience crawling and achy feelings in your legs during the day or night which makes you want to move them or walk?	☐ NO ☐ YES, *EXPLAIN:*
If you do experience achy feelings in your legs, do you notice it is worse at night?	☐ NO ☐ N/A ☐ YES, *EXPLAIN:*
Have you been told that your arms or legs move frequently during the night?	☐ NO ☐ YES, *EXPLAIN:*
Are your bedcovers in total disarray in the morning?	☐ NO ☐ YES, *EXPLAIN:*
Are you told that you act out your dreams or nightmares by swinging your arms, legs or by moving or yelling? If so, do these events occur early or late during the sleep period?	☐ NO ☐ YES, *EXPLAIN:*
Have you hurt yourself or others while acting out behaviors / dreams in your sleep?	☐ NO ☐ YES, *EXPLAIN:*
Have you been told that you sleep walk?	☐ NO ☐ YES, *EXPLAIN:*
Do you have thoughts racing through your mind while trying to fall asleep?	☐ NO ☐ YES, *EXPLAIN:*
Do you watch a clock while trying to sleep?	☐ NO ☐ YES, *EXPLAIN:*
Do you have anxiety which keeps you from sleeping?	☐ NO ☐ YES, *EXPLAIN:*
Do you have muscle tension which disrupts your ability to fall asleep or stay asleep?	☐ NO ☐ YES, *EXPLAIN:*
Are you bothered by pain during the day or night?	☐ NO ☐ YES, *EXPLAIN:*
Do you experience morning jaw pain?	☐ NO ☐ YES, *EXPLAIN:*

S.T.O.P. BANG QUESTIONNAIRE			
	Please check any of the following that apply to you:	**Yes**	**No**
1.	Do you snore loudly?	□	□
2.	Do you often feel tired, fatigued or sleep during the day?	□	□
3.	Has anyone observed you stop breathing during your sleep?	□	□
4.	Do you have or are you being treated for high blood pressure?	□	□
5.	Are you obese or very overweight – BMI > 35 kg/m2?	□	□
6.	Are you 50 years of age or better?	□	□
7.	Is your neck circumference > 16 inches (female) 17 inches (male)?	□	□
8.	Are you male?	□	□
A score of 3 or more 'Yes' answers indicates a significant likelihood of sleep apnea. Score:			

EPWORTH SLEEPINESS SCALE					
Please rate your likelihood to doze off in the following situations:		Never	Slight	Moderate	High
1.	Being a passenger in a motor vehicle for an hour or more	0 □	1 □	2 □	3 □
2.	Sitting and talking to someone	0 □	1 □	2 □	3 □
3.	Sitting and reading	0 □	1 □	2 □	3 □
4.	Watching Television	0 □	1 □	2 □	3 □
5.	Sitting inactive in a public place	0 □	1 □	2 □	3 □
6.	Lying down to rest in the afternoon	0 □	1 □	2 □	3 □
7.	Sitting quietly after lunch, without alcohol	0 □	1 □	2 □	3 □
8.	In a car, while stopped for a few minutes in traffic	0 □	1 □	2 □	3 □
Sum of all numbers checked above = Total Score: /24					

AUTHORIZATION TO VERBALLY DISCLOSE MY HEALTH INFORMATION – HIPAA DISCLOSURE	
PATIENT NAME:	DOB:

1. AUTHORIZATION: YOU MAY DISCLOSE THE FOLLOWING INFORMATION REGARDING MY HEALTH CARE, (PLEASE CHECK ALL THAT APPLY):

☐ ALL INFORMATION IN MY MEDICAL RECORD

☐ ONLY HEALTH CARE INFORMATION RELATING TO THE FOLLOWING TREATMENT OR CONDITION:

☐ ONLY HEALTH CARE INFORMATION RANGING BETWEEN THE FOLLOWING DATES:

☐ YOU MAY VERBALLY DISCLOSE MY INFORMATION TO:

NAME:	RELATIONSHIP
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:

AUTHORIZATION DURATION: ☐ INDEFINITE ☐ EXPIRES ON:

2. PATIENT RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I also understand that this authorization only covers verbal disclosures. Washington State Law (RCW 70.02) requires that a written authorization be signed for releases of protected health information other than verbal disclosures, and a written authorization of that type is only good for 90 days.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Atlas Sleep Diagnostics based upon this authorization.

PATIENT OR LEGAL GUARDIAN SIGNATURE:	DATE:	TIME:
PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT:	RELATIONSHIP:	

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may also see your record or request a copy of these records via our web portal. Call our office to set up an account. Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge I was offered the Notice of Privacy Practices.

PATIENT OR LEGAL GUARDIAN SIGNATURE:	DATE:	TIME:
PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT:	RELATIONSHIP:	

OFFICE POLICIES AND FINANCIAL AGREEMENT

APPOINTMENTS**:** We value your time and we understand that often circumstances arise that warrant changing a scheduled appointment or sleep study. We do ask that you provide a 24 hour notification of cancellation, otherwise we charge a cancellation fee which is not covered insurance.

CO-PAYMENTS & CO-INSURANCE**:** Often your insurance will require that you pay a co-pay for office visits. These charges are based on the contractual agreement you have with your insurance and we require payment at time of service. Additionally, office visits and sleep studies will be paid based on the fees your insurance will allow and a co-insurance is the patient's responsibility. Often this ranges between 15-30% of the insurance allowable and may be required at time of service as well. We are happy to review this with you, should you have questions and will generally provide this information prior to services being rendered.

PRESCRIPTION REFILLS**:** Please call your pharmacy whenever you need a prescription refilled, even if your bottle indicates no refills available. This process may take up to 3 business days.

PAYMENT FOR SERVICES**:** I understand that I am individually responsible for all payments of any charges and to determine eligibility with my insurance company. I am aware that these policies may change without notice and a copy of this agreement is available to me at my request.

I understand and accept the terms of the above described policies that apply to the practice of Atlas Sleep Diagnostics.

PATIENT OR GAURDIAN SIGNATURE:	PRINTED NAME:	DATE:
RESPONSIBLE PARTY SIGNATURE:	PRINTED NAME:	DATE: