Monica Otero Woodward, M.D., FCCP, FAASM
Medical Director

Martin A. Cohn, M.D., FACP, FAASM
Director Emeritus, Retired 2012

Amy R. Mendes, ARNP-BC
Sleep Medicine Provider

Sleep Disorders Center
OF SW FLORIDA
Dedicated to the Treatment of Sleep and Pulmonary Disorders

NEW PATIENT APPOINTMENT AND FORMS

These new patient forms are being mailed to you as a convenience to allow sufficient time for completion prior to your scheduled appointment:

_____

DAY DATE TIME

Bring the completed forms with you to the appointment.

IF YOU CANNOT COMPLETE THESE FORMS BEFORE ARRIVAL AT YOUR APPOINTMENT, PLEASE CALL TO RESCHEDULE YOUR APPOINTMENT.

Cancellations should be made 24 hours prior to your scheduled Appointment, except in an emergency situation.

You may print the forms off our web site, www.sleepcenternaples.com, Please feel free to call us if you need any assistance in printing the forms. We'll be glad to help you.

If you are being evaluated for insomnia and a sleep diary has been mailed to you, please follow the instructions on the form. Record your sleep pattern day and/or night for as long as time permits prior to your appointment. It's extremely important to the doctor to be able to get an overall view of your recent sleep pattern documented in the diary.

Please request medical records from any other physician(s) you see. They can be faxed to our office at 239-254-1255

Please bring your driver's license and insurance cards with you for the first visit so we may make scan them. Please feel free to call if you have any questions.

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REGISTRATION FORM

Patient's name:	Date:
Date of birth:	Place of birth:
Sex (please circle): M F	Marital status: married single divorced widowed

Permanent address:
City/state/zip code:
Home Phone: Mobile Phone:
Email address:
Employer:
Employer phone number:
Nearest relative/Emergency Contact:
Relationship:
Phone number:
Referring Physician:

INSURANCE INFORMATION

Insured's Name:	
Insured's Date of Birth:	Relationship to patient:
Primary Insurance:	Secondary Insurance:
Policy #:	Policy #:

Please bring your insurance cards along with your driver's license (or other photo ID) to your first visit. We will make scan them for our records.

Billing Procedures

I understand that I am fully responsible for the amounts billed to me for professional services rendered to me that are not covered by Medicare and/or my insurance including the deductible and co-payments. I will be expected to pay my co-payments at each visit.

The billing department will bill my insurance and will send me a statement with my balance due which I may pay by cash, check, MasterCard, or Visa. If needed, I may discuss a monthly payment plan with the Accounts Manager. I understand Monica O. Woodward, MD, will not accept Workman's Compensation, disability, or accident insurance.

Patient Signature: _____ Date: _____

1865 Veterans Park Drive, Suite 301, Naples, FL 34109-0447
Tel 239.254.1233 * www.sleepcenternaples.com * Fax 239.254.1255

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, SLEEP DISORDERS CENTER OF SOUTHWEST FLORIDA, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis of planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- 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

I understand that SLEEP DISORDERS CENTER OF SOUTHWEST FLORIDA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that SLEEP DISORDERS CENTER OF SOUTHWEST FLORIDA reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should this practice change their notice, they will send copy of any revised notice to the address I have provided, (whether U.S. mail, or if I agree, by email.)

I wish to have the following restrictions to use or disclosure of my health information:
_____
I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____
Patient Signature Date

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MEDICAL RECORDS RELEASE FORM

Date: _____

_____ _____
PATIENT NAME SOCIAL SECURITY #

_____ _____
ADDRESS DATE OF BIRTH

_____
CITY, STATE, ZIP

I, _____, hereby give authorization to release my medical records to the above entity.

History & Physical	Pathology reports	Bronchoscopy reports
Last office visit	Pulmonary function testing	Operative reports
Sleep study reports	Radiology reports	Discharge summary

_____
PHYSICIAN / HEALTH CARE FACILITY

_____
ADDRESS

_____
CITY, STATE, ZIP

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

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SLEEP QUESTIONNAIRE

Name:	Profession:		Sex: ☐ Male ☐ Female
Birth date:	Age:	Birthplace:	
Referring physician:		Telephone:	
Primary physician:		Telephone:	
Today's date:			
Chief complaint:			
When did your sleep problem begin?			

Is this the first time you consult a sleep specialist? ☐ **Yes** ☐ **No**
If **No**, when and whom did you consult?

Briefly explain your sleep problem.

Please enter the usual time that you

	Workdays	**Days off**
At what time do you go to bed for sleep		
At what time do you Arise in the morning		
How many hours do you sleep most nights		
Do you nap		

1865 Veterans Park Drive, Ste 301
Naples, FL 34109-0447

Telephone 239.254.1233
Facsimile: 239.254.1255

Caffeine consumption: On average how many caffeinated beverages do you drink each day?

Type of beverage	**Daily consumption**
Cups of American style coffee	
Cups of espresso style coffee	
Cups of caffeinated tea	
Cans of caffeinated sodas	
Cans of caffeinated energy drinks	

Alcohol consumption: On average how much alcohol do you drink each week?

Type of alcoholic beverage	**Weekly consumption**
Glasses of wine	
Cans of beer	
Number of cocktails	

Family History: Do your parents or siblings have

Asthma	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Dementia (Alzheimer)	☐ Yes	☐ No	Restless Legs Syndrome	☐ Yes	☐ No

Sleeping Medications: Have you ever regularly used sleeping pills? ☐**Yes** ☐**No**
If yes, please list current and prior sleeping medications.

Name of sleep medication	**Name of sleep medication**

Prescription medications: Please list the medications that you take regularly.

Name of medication	**Name of medication**

Medical and Surgical History: Please check off **your surgeries** and **known medical diagnosis**

Surgery	~Year	Medical diagnosis	~Year diagnosed
☐ Nasal		☐ Allergies-nasal, sinus	
☐ Tonsils		☐ Asthma	
☐ Adenoids		☐ High blood pressure	
☐ Throat		☐ High Cholesterol	
☐ Thyroid		☐ Heart Attack	
☐ Lung		☐ Heart Arrhythmia	
☐ Heart		☐ Diabetes	
☐ Stomach or Intestine		☐ Reflux or heartburn	
☐ Gallbladder		☐ Stroke or TIA	
☐ Urinary Tract		☐ Chronic Lung Disease	
☐ Back surgery		☐ Depression	
☐ Brain surgery		☐ Anxiety	
☐ Other (please list)		☐ Thyroid Disorder	
		☐ Hepatitis	
		☐ Other (please list)	

Sleep Patterns: Please describe the **typical** experience over the period of time since developing your sleep problem.

Does it usually take you more than 30 minutes to fall asleep?	☐ **Yes**	☐ **No**
Do you usually have trouble sustaining sleep?	☐ **Yes**	☐ **No**
Do you wake up prematurely and find it difficult to resume sleep?	☐ **Yes**	☐ **No**
Do you often feel tired, fatigued or sleepy during the day?	☐ **Yes**	☐ **No**
Does napping and/or longer sleep make you feel better?	☐ **Yes**	☐ **No**
Do you dream during naps?	☐ **Yes**	☐ **No**
Do dreams interfere with your sleep?	☐ **Yes**	☐ **No**
Have you ever experienced muscle weakness in any part of the body:	☐ **Yes**	☐ **No**
a. After telling and/or hearing a joke?	☐ **Yes**	☐ **No**
b. After a hardy laugh?	☐ **Yes**	☐ **No**
c. After becoming angry?	☐ **Yes**	☐ **No**
When awakening, have you found yourself briefly unable to move?	☐ **Yes**	☐ **No**
Have you experienced dreaming while awake?	☐ **Yes**	☐ **No**
Did you see a psychologist or psychiatrist for your sleep problem?	☐ **Yes**	☐ **No**

Symptoms that may disturb sleep:

My skin itches, burns, or otherwise often creates for my sleep.	☐ **Yes**	☐ **No**
I often have nasal blockage or stuffiness.	☐ **Yes**	☐ **No**
I often have nosebleeds.	☐ **Yes**	☐ **No**
I often wake up with a dry mouth.	☐ **Yes**	☐ **No**
I drool during sleep.	☐ **Yes**	☐ **No**
Cough often awakens me from sleep.	☐ **Yes**	☐ **No**
My snoring regularly disturbs others.	☐ **Yes**	☐ **No**
My snoring can be heard through a closed door.	☐ **Yes**	☐ **No**
I am told that I stop breathing when I sleep.	☐ **Yes**	☐ **No**
I awaken from sleep because of choking, gasping or short of breath	☐ **Yes**	☐ **No**
Wheezing often awakens me from sleep.	☐ **Yes**	☐ **No**
Chest pressure often awakens me from sleep.	☐ **Yes**	☐ **No**
Fast or irregular heart rate often awakens me from sleep.	☐ **Yes**	☐ **No**
Heartburn often awakens me from sleep.	☐ **Yes**	☐ **No**
Stomach or colon pain often awakens me at night	☐ **Yes**	☐ **No**
I often wake up needing to pass gas.	☐ **Yes**	☐ **No**
I have had episodes of bedwetting as an adult.	☐ **Yes**	☐ **No**
The need to urinate awakens me from sleep at least twice each night.	☐ **Yes**	☐ **No**
I often wake up with headaches.	☐ **Yes**	☐ **No**
My legs bother me when I am trying to fall asleep.	☐ **Yes**	☐ **No**
I often have panic attacks.	☐ **Yes**	☐ **No**
I am claustrophobic.	☐ **Yes**	☐ **No**
My legs move a lot while I sleep.	☐ **Yes**	☐ **No**
I have hurt myself while asleep.	☐ **Yes**	☐ **No**
I have hurt my bed partner while asleep.	☐ **Yes**	☐ **No**
I have acted out dreams by moving while asleep	☐ **Yes**	☐ **No**
I have fallen out of bed during sleep.	☐ **Yes**	☐ **No**
I have had episodes of sleep walking.	☐ **Yes**	☐ **No**
I often talk during my sleep.	☐ **Yes**	☐ **No**
I sweat too much when sleeping.	☐ **Yes**	☐ **No**
I wake up to drink water more than once each night.	☐ **Yes**	☐ **No**
I often have fever during sleep.	☐ **Yes**	☐ **No**
My joints get hot and red when sleeping.	☐ **Yes**	☐ **No**
I have woken up with unexplained bruising.	☐ **Yes**	☐ **No**
I have woken up with blood in the whites of my eyes.	☐ **Yes**	☐ **No**
Pain often awakens me from sleep.	☐ **Yes**	☐ **No**
Muscle cramps often awaken me from sleep.	☐ **Yes**	☐ **No**

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to usual way of life in recent times. Even if you have not 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	**Number**
Sitting and reading	
Watching television	
Sitting, inactive in a public place (e.g. a theater 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 traffic	
Total number	

Name:_____

Date: _____