College Station Center for Pulmonary and Sleep Disorders

1602 Rock Prairie Rd., Suite 2000 College Station, TX 77845
phone: 979.694.1300 fax: 979.694.1313
www.cslungandsleep.com

Patient's Name _____ DOB _____

Social Security # _____

Address _____

City _____ State _____ Zip _____

EMAIL ADDRESS _____

Home Phone (_____) _____- _____

Work Phone (_____) _____- _____

Cell Phone (_____) _____- _____

Spouse's Name (Guardian, if minor) _____

Contact Phone (_____) _____- _____

Patient's Employer _____

Emergency Contact Person _____ ❑ see above

Relationship _____

Contact Phone (_____) _____- _____

Insurance Information

Primary Coverage ❑ Card on chart

Person Insured: ❑ Self ❑ Spouse ❑ Other/Relationship _____

Name of Insured _____

Insured's DOB _____ Insured's SS# _____

Insured's Employer _____

Employer's phone number (_____) _____- _____

Secondary Coverage ❑ Card on chart

Person Insured: ❑ Self ❑ Spouse ❑ Other/Relationship _____

Name of Insured _____

Insured's DOB _____ Insured's SS# _____

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Patient's Name _____ DOB

Confidential Communications of Protected Health Information

I request communication of my protected health information by the following means and at the following numbers. I understand this request applies only to communications from College Station Center for Pulmonary and Sleep Disorders to me, the patient, and the communications that would be sent to the named insured of an insurance policy that covers the patient as a dependent of the named insured. This request will remain in effect until you notify us of a change.

Please indicate your preference for how we contact you.

First (_____) _____- _____ home work cell

Second (_____) _____- _____ home work cell

Third (_____) _____- _____ home work cell

You may leave information on answering machine ❑ Yes ❑ No

You may leave information with _____

Relationship: ❑ Spouse ❑ Significant Other ❑ Parent ❑ Other _____

This office has a Privacy Practice Policy available at the front window and in the waiting room. This policy has been offered to me and I have been provided the opportunity to review and ask questions.

Signature _____ Date _____

Relationship if not patient _____

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ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE RENDERED, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE

1) Your medical coverage is determined by your insurance company. Please contact your insurance provider to confirm your benefits.
2) Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
   a. You are required to pay your co-payments at the time of each visit.
   b. For unpaid claims over 45 days, it is your responsibility to follow-up with your insurance carrier, and the balance due is considered due and payable.
3) It is your responsibility to notify our front desk staff of any insurance, address or phone number changes.
4) You will be responsible for any charges that occur if we are not notified of changes.

Patient Authorization for Payment

I understand that payment is due for services rendered.

I authorize Regional Employee Assistance Program to submit insurance claims using my signature on file below.

I authorize the release of medical information necessary in order to process this assignment on the claim.

I authorize payment of medical benefits to be paid directly to Regional Employee Assistance Program for services described on the claim form.

Patient's Name_____ DOB_____

Signature_____ Date_____

Relationship if not patient_____

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This office may at times use an electronic prescription system which allows prescriptions and related information to be electronically sent between College Station Center for Pulmonary and Sleep Disorders and your pharmacy.

Patient Authorization for Electronic Prescribing

I have been made aware and understand that this office utilizes an electronic prescription system. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to College Station Center for Pulmonary and Sleep Disorders to use electronic prescribing on my behalf and to see this protected health information.

Patient's Name_____ DOB_____

Signature_____

Relationship to patient, if not patient_____

Witness' Signature_____

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Thank you for choosing our office for your healthcare needs! Please take a moment to let us know how you were referred.

How did you hear about us?

- ☐ Physician referral, _____ (physician name)
- ☐ Internet
- ☐ Newspaper
- ☐ Friends/family
- ☐ Senior Circle
- ☐ Healthy Women
- ☐ Radio
- ☐ Billboard
- ☐ Yellow pages
- ☐ Other, _____

Name_____ Date_____

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Name: _____ DOB: _____ Age: _____ Date: _____

E-MAIL ADDRESS: _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy: _____

DME Supplier (for oxygen, CPAP, etc): _____

Reason for Office Visit: _____

Where is your discomfort located? (E.g. head; chest):

Please describe your discomfort? (E.g. hacking cough; sharp pain):

How severe is your discomfort? Is it constant or intermittent? (E.g. moderate, intermittent):

What appears to make your discomfort better? Worse?

How long have you had this discomfort? (E.g. 1 month):

In what context did your discomfort start? (E.g. recent travel, sick contacts):

What other symptoms do you have associated with this discomfort? (E.g. fever, night sweats):

Medications: Please include a list of your current medications or bring your medication bottles to your appointment.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

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Name _____ DOB _____

Review of Symptoms (check any symptoms you have had in the **last 4 months**. Unchecked boxes are interpreted as symptom(s) not present.)

General
- ❑ Weight loss _____#/1yr
- ❑ Weight gain____#/5yrs
- ❑ Fever
- ❑ Night sweats
- ❑ Loss of appetite
- ❑ Recent foreign travel or long distance travel

Sleep
- ❑ Sleep poorly
- ❑ Insomnia
- ❑ Daytime fatigue
- ❑ Snoring
- ❑ Pauses of breathing during sleep
- ❑ Fall asleep inappropriately
- ❑ Drowsy Driving

Neurological
- ❑ Frequent Headaches
- ❑ Hand/Feet numbness
- ❑ Unsteady or falling
- ❑ Dizziness
- ❑ Memory loss

Chest/Cardiovascular
- ❑ Chest pain
- ❑ Palpitations
- ❑ Irregular heartbeat
- ❑ Legs swelling

Head/Eyes/Ears
- ❑ Trouble hearing
- ❑ Sinus/Nasal congestion
- ❑ Vision changes
- ❑ Seasonal allergies
  Which season?: spring/ winter/fall/summer
- ❑ Sore throat
- ❑ Hoarseness

Bones, Joints, Muscles/Musculoskeletal
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle weakness

Blood/Hematological
- ❑ Swollen glands
- ❑ Bleeding problems
- ❑ Bruise easily

Endocrine
- ❑ Excessive thirst
- ❑ Excessive urination
- ❑ Elevated blood sugars

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Suicidal thoughts

Lungs/Respiratory
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Sputum production
- ❑ Ever coughed up blood
- ❑ Shortness of breath lying down
- ❑ Pleurisy
- ❑ Smothering
- ❑ Low oxygen levels

Skin/Dermatalogical
- ❑ Rash
- ❑ Non-healing sore/spot
- ❑ Skin swelling/lumps

Stomach/Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn/reflux
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Blood in stools
- ❑ Difficulty swallowing
- ❑ Cough/chocking with eating

Bladder/Urological
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Difficulty urinating
- ❑ Incontinent

Vaccinations Current ?

❑ Yes ❑ No Pneumonia: ❑ Need ❑ Received (year) _____

❑ Yes ❑ No Flu (annually): ❑ Need ❑ Received (year) _____

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Name _____ DOB _____

Past Medical History (Check all conditions you have ever been told you have):

- ❑ Heart attack or blocked vessels/Coronary Artery Disease
- ❑ Heart failure
- ❑ Arrhythmias
- ❑ Valve disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ COPD/emphysema
- ❑ Asthma
- ❑ Chronic bronchitis
- ❑ Stroke/TIA
- ❑ Intestinal bleed
- ❑ Hiatal hernia
- ❑ Blood clots
- ❑ Seasonal Allergies
- ❑ Diabetes
- ❑ Thyroid disorder
- ❑ Rheumatoid arthritis
- ❑ GERD/Peptic ulcer
- ❑ Cancer, Type _____

❑ Obstructive Sleep Apnea

Date of sleep study: _____ Lab where performed: _____

I use CPAP every night ❑ Yes ❑ No

My CPAP/BiPAP settings are: _____

CPAP Supplier/DME company: _____

❑ Oxygen: ❑ All the time ❑ When walking ❑ Only at night ❑ As needed ❑ Rate_____L/min

O2 Supplier/DME company: _____

Past Surgical History

- ❑ Heart Bypass/CABG
- ❑ Gallbladder removed
- ❑ Abdominal surgery
- ❑ Tonsillectomy
- ❑ Sinus surgery
- ❑ Hysterectomy
- ❑ Appendectomy

Other surgeries not listed: _____

_____

_____

Family Medical History (medical conditions found in your family):

Mother:	**Father:**	**Sibling** (please indicate which sibling):
_____	_____	_____
_____	_____	
_____	_____	
_____	_____	

Other conditions: _____

Social History: ❑ single ❑ widowed ❑ divorced ❑ married

❑ Never smoked

❑ Former smoker _____average packs/day x _____years, year quit _____

❑ Current smoker _____average packs/day x _____years

Alcohol use: ❑ Never ❑ Social ❑ Daily

Known occupational exposures: ❑ Asbestos ❑ Dust ❑ Hydrocarbons/chemicals

Current Pets: ❑ Dog ❑ Cat ❑ Bird

Medication Allergies: _____ Type of reaction?

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Sleep Schedule

1. What is your usual Bedtime?
2. How long does it typically take you to fall asleep?
3. What time do you typically wake up for your day?
4. During the night how many times would you typically awaken?
5. What are your reasons for awakening?
6. How long does it take you to fall back asleep after an awakening?
7. ❑ Yes ❑ No Upon awakening for your day do you feel refreshed?
8. ❑ Yes ❑ No Do you have a headache upon waking up?
9. ❑ Yes ❑ No Do you have a mid-afternoon dip in energy level?
10. ❑ Yes ❑ No Do you take naps during the day?
    Naps are: ❑ Refreshing ❑ Not Refreshing
    Duration of naps _____
11. How many caffeinated products (tea, coffee, energy products) do you consume daily?
    When is the last consumed?
12. How many alcoholic beverages do you consume daily?
13. Describe your usual routine the hour prior to going to bed?

14. ❑ Yes ❑ No Are you a shift worker?
    What is your shift schedule?
15. ❑ Yes ❑ No Do you have racing or intrusive thoughts at bedtime?
16. ❑ Yes ❑ No Do you have a history of depression?
17. ❑ Yes ❑ No Do you have a history of anxiety disorder or PTSD?
18. ❑ Yes ❑ No Have you been told you snore?
19. ❑ Yes ❑ No Do you have pauses in breathing or gasping when asleep?
20. ❑ Yes ❑ No Do you have episodes of acting out what you're dreaming?
    If yes, do you have a family of neurologic disease? ❑ Yes ❑ No
21. ❑ Yes ❑ No Do you see, hear or feel things you know are not there?
22. ❑ Yes ❑ No Have you had episodes where you are awake but unable to move or talk?
23. ❑ Yes ❑ No Have you experienced weakness or collapse when laughing or when startled?
24. ❑ Yes ❑ No Do you have unusual sensations in your arms or legs at bedtime or when seated with an urge to move your limbs for relief?
25. Do you have any of the following?
    - ❑ Yes ❑ No Sleep Walking
    - ❑ Yes ❑ No Sleep Talking
    - ❑ Yes ❑ No Night Terrors
    - ❑ Yes ❑ No Bedwetting

Epworth Sleepiness Scale - score each situation with how likely you think you are to doze or fall asleep during *normal* day to day activities: **0** = would never doze **1** = slight chance of dozing **2** = moderate chance of dozing **3** = high chance of dozing

Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting inactive in a public place (i.e. theater or meeting)	0	1	2	3	
Riding as a passenger in a car for one hour without a break	0	1	2	3	TOTAL
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	SCORE
Sitting and talking with someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	_____
Sitting in a car as the driver, while stopped for a few minutes in traffic	0	1	2	3	