



# LUNG & SLEEP SPECIALISTS OF NORTH TEXAS

Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sex: \_\_\_\_ Male \_\_\_\_ Female Social Security Number \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

Marital Status (Please circle one) Single Married Separated Divorced Widow/Widower

Language: \_\_\_\_\_ Race: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently using a DME (Durable Medical Equipment) Company? If yes \_\_\_\_\_

## Insurance Information

Responsible party for paying bill: Patient Parent Spouse Other

Primary Insurance name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group number: \_\_\_\_\_

Secondary Insurance name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group number: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring provider: \_\_\_\_\_



**ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT**

Due to the Health Insurance Portability and Accountability Act (HIPAA\_ of 1996), the following information must be filled out by each patient annually.

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment. I give Lung & Sleep Specialist of North Texas, providers and employees my permission to discuss freely my conditions, treatment or diagnosis with the person present. YES or NO

Please mark if we may leave a detailed message:

Home Phone                      Work                      Cell Phone                      Email: \_\_\_\_\_

May we call your name out in the Lobby? YES or NO

With whom may we discuss your information about your care, treatment and Diagnosis?

Name: \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_

Name: \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_

**Office Policy on Payments**

Payment is due at the time services are rendered, unless prior arrangements have been made with the Office manger. This includes co pays, coins and deductibles.

Our practice charges a \$25.00 fee for Returned Checks, Medical records request, FMLA and Disability forms that need to be completed.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**Authorization for release of medical records**

I authorize the Lung and Sleep Specialists of North Texas to release any medical information including diagnosis, radiograph, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for the information.

**I have read the above and accept financial responsibility in full for this account.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



### **MEDICATION PRESCRIPTION POLICY & AGREEMENT**

The following is an outline of our medication prescription refill policy at Lung and Sleep Specialists of North Texas

1. Please call your pharmacy for any refills. Your pharmacy will call or fax us a request.
2. We require a 24hr notice on refills. To ensure you don't run out.
3. We DO NOT refill medications after business hours or on weekends.
4. Any medication refills received after 4:00 pm will be addressed the next business day.
5. Samples will only be given out if you are compliant with your visits as scheduled.

### **AFTER BUSINESS HOURS & WEEKENDS**

Our business hours are 8:30am to 5:00pm Monday through Thursday, Friday 8:30am to 2pm. In the case of an emergency, life-threatening situations, or concerning symptoms, call 911 or proceed to the nearest emergency room.

Our providers do NOT have access to your health information records after business hours or weekends.

All routine appointments must be made during our business hours listed above.

### **Appointment Cancellation Policy**

We require a 24 hr notification for all cancellations. If you fail to notify our office within 24 hrs we charge a "NO SHOW" fee for routine follow up visits \$25/New patients \$50/PFT \$100/Sleep Study \$100.

A great deal of time and preparation is put into assuring your appointment time is customized to your needs and we provide ourselves in making sure you are given the appropriate time and attention you deserve regarding your medical care. Please help us ensure that we can continue that level of care by giving us the courtesy of timely cancellations so that we may give that same attention to others in need.

Please bring all your medications to your appointment. A list of name, strength and how you take or you may bring bottles.

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

I have read and understand the above policies and agree to adhere to the policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Please check ALL that apply within the last SIX (6) months**

Constitutional

- Good general health lately
- Recent weight change
- Fever
- Fatigue
- Headaches
- Snoring
- Hoarseness
- Arthritis
- Abnormal chest x-ray

Eyes

- Eye diseases or injury
- Wear glasses or contacts lenses
- Blurred or double vision
- Glaucoma

ENT

- Hearing loss
- Ringing in the ears
- Earaches or drainage
- Sinus problems
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breathe or bad taste
- Sore throat or voice change
- Swollen glands in neck

Cardiovascular

- Heart trouble
- Chest pain
- Sudden heart beat changes
- Swelling of feet, ankles, or hands

Respiratory

- Frequent coughing
- Spitting up blood
- Shortness of breath
- Asthma/wheezing

Gastrointestinal

- Loss of appetite
- Change in bowel
- Nausea or vomiting
- Frequent diarrhea
- Painful bowel movement or constipation
- Blood in stool
- Stomach pain

Genitourinary

- Frequent urination
- Burning or painful urination
- Blood in urine
- Change in force when urinating
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male-Testicle pain
- Female-irregular periods
- Female-Vaginal discharge
- Female # of pregnancies \_\_\_\_\_
- # of miscarriages \_\_\_\_\_

Female last pap smear \_\_\_\_\_  
was it normal Yes or No

Musculoskeletal

- Joint pain
- Joint stiffness or swelling
- Weakness of muscle or joints
- Back pain
- Cold extremities
- Difficulty in walking

Skin

- Rash and itching
- Change in skin color
- Change in hair or nails
- Varicose veins
- Breast pain
- Breast lump
- Breast discharge

Neurological

- Frequent or reoccurring headaches
- Light headed or dizzy
- Convulsion or seizures
- Numbness or tingling sensations
- Tremors
- Paralysis
- Stroke
- Head injury

Psychiatric

- Memory loss or confusion
- Nervousness
- Depression
- Sleep problems

Endocrine

- Glandular or hormone problems
- Thyroid disease
- Diabetes
- Excessive thirst or urination
- Heat or cold intolerance
- Dry Skin
- Change in hat or glove size

Hematologic/Lymphatic

- Slow to heal after surg
- Easily bruise or bleed
- Anemia
- Phlebitis
- Past transfusion
- Enlarge glands

Allergic/Immunologic

- History of skin reaction
- Or other adverse reactions to:
- Penicillin or antibiotics
- Morphine, Demerol, narcotics
- Novocaine or anesthetic
- Aspirin or other OTC pain meds
- Tetanus antitoxin or other serum
- Lodine, methiolate, or other antiseptics
- Other drug allergies

Food allergies

\_\_\_\_\_

\_\_\_\_\_



Surgical history: \_\_\_\_\_

\_\_\_\_\_

Past chest x-rays: List most recent first and location

\_\_\_\_\_

\_\_\_\_\_

Smoking history:

Have you ever smoked? Yes or No How many packs per day? \_\_\_\_\_

Exposure to second hand tobacco smoke? Never rarely occasionally often regularly

Occupational/Hobbies/Activities:

List any jobs or activities where you exposed routinely to chemicals, powders, dusts, other types of hazardous materials (i.e. ceramics or remodeling).

Years of exposure

Type of hazardous exposure (i.e. Powder, dust, fumes, chemicals, household cleaners)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weight loss or gain: Yes or No

Social activities:

Alcoholic beverages? Beer Wine mixed drinks hard liquor  
 Substance abuse now or in the past? Marijuana Cocaine Narcotics Valium LSD  
 IV drug use

Family history:

Parents	Alive	Deceased age
Mother	<input type="checkbox"/>	<input type="checkbox"/> _____
Father	<input type="checkbox"/>	<input type="checkbox"/> _____
Brother	<input type="checkbox"/>	<input type="checkbox"/> _____
Brother	<input type="checkbox"/>	<input type="checkbox"/> _____
Sister	<input type="checkbox"/>	<input type="checkbox"/> _____
Sister	<input type="checkbox"/>	<input type="checkbox"/> _____
Mothers side:		
Grandfather	<input type="checkbox"/>	<input type="checkbox"/> _____
Grandmother	<input type="checkbox"/>	<input type="checkbox"/> _____
Fathers side:		
Grandfather	<input type="checkbox"/>	<input type="checkbox"/> _____
Grandmother	<input type="checkbox"/>	<input type="checkbox"/> _____



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## Respiratory symptoms:

Answer if you have shortness of breath

- On exertion
- At rest
- When lying flat

How long have you had symptoms?

- Less than 6 months
- 6 – 12 months
- 1 – 3 years
- 3 – 5 years
- 5 – 10 years
- Greater than 10 years

Does your shortness of breath improve after coughing up sputum? Yes or No

Does your shortness of breath come on suddenly? Yes or No

Is your shortness of breath associated with any of the following symptoms?

- Drenching sweat
- black outs
- pounding heart
- chest pain
- wheezing
- Swollen legs
- fever
- chills
- nausea

## Cough:

How long have you had trouble with coughing?

- Less than 1 month
- 1 – 3 months
- 3 months to a year
- 1 – 2 years
- More than 2 years

Has your cough changed recently? Yes or No

Does your cough produce sputum? Yes or No

If yes, what color?

- Clear
- Yellow white
- Green
- Tan
- Brown red
- Other

How much sputum do you produce over 24 hrs?

- Less than 2 tablespoons
- More than 2 tablespoons

## Chest pain:

When do you experience chest pain? On exertion at rest after meals

How long does pain last? Few seconds 5 minutes 15 minutes 1 hour all day

How many years have you had chest pain? 1-3 years more than 3 years

What makes the pain go away? Resting eating



## Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never doze or sleep
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or sleeping
Sitting and reading	_____
Watching TV	_____
Being a passenger in a motor vehicle For an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
	Total: _____

Name: \_\_\_\_\_ Date: \_\_\_\_\_



Dear Patient,

Sleep problems are extremely common. Breathing disorders of sleep alone affect 4% of women and 9% of men between the ages of 30 and 60 in this country. Insomnia is present in 15% to 20% of the population on chronic basis. All of these disorders affect daytime wakefulness to different degrees in each person. For instance, some people with moderately severe apnea claim to have little or no symptoms to daytime fatigue, while some individuals who only manifest snoring during sleep may feel terribly sleepy during the day. Obviously, each person must use his or her best judgement to determine if placing himself or herself in a particular setting/situation (for example: driving a car, using heavy machinery, or working at heights) which might lead to them harming himself, herself or others.

You should be aware that any nighttime sleep disturbance may cause daytime drowsiness and therefore could impair your ability to operate heavy machinery, especially a motor vehicle. You should not expose yourself to others to harm because of your potential drowsiness.

For your protection we require verification that you have received this notice. Therefore, please sign below and bring with you to your appointment.

Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sleep Questionnaire:

Please complete this questionnaire as it will help the providers help you. Some questions are personal, you may leave blank and discuss them with the provider if you wish.

Please briefly describe your sleep complaints, including when they started.

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- |  |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|
| Did you have a problem with your sleep as a child?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Are you unable to fall asleep at night?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Are you unable to remain asleep at night?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you commonly wake up earlier than you would like?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you use an alarm clock to wake up in the morning?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Is it easy for you to get out of bed in the morning?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you feel you get too much or not enough sleep at night?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you feel that the quality of your sleep is unsatisfactory?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Have you ever been told you snore?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your snoring disturb others in your home?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you sometimes wake up choking, breathing hard, or gasping for a breath?                                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Have you dreamed of drowning or being suffocated?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you wake up at night with heartburn?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you wake up coughing?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you sweat excessively during sleep?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Is your sleep often restless and disturbed?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Have you ever wet the bed during sleep as an adult?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you get an uncomfortable, hard to describe feeling in your legs or elsewhere that increases in intensity? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do these worsen when sitting or lying down, especially in the late evening or night?                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does this feeling create a demanding need to move the legs or body to relieve the feeling?                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you get relief of these symptoms by activity (walking, stretching, and bending) at least temporary?       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does pain disturb your sleep? If yes describe: _____   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |





**LUNG & SLEEP  
SPECIALISTS  
OF NORTH TEXAS**

- Do you commonly wake up in the morning with a sore throat or hoarseness?  Yes  No
- Do you wake up in the morning with a headache?  Yes  No
- Do you have hallucinations or dream like mental images during sleep?  Yes  No
- Do you have attacks of sudden physical weakness or paralysis during the day?  Yes  No
- If so does laughing, anger, or other emotional factors trigger the attacks?  Yes  No
- Do you have hallucinations or dream like metal images when you are falling asleep or waking up?  Yes  No
- Do you ever feel paralyzed when falling asleep or as you are waking up?  Yes  No
- Do you often have frightening dreams or nightmares?  Yes  No
- Do you ever wake up screaming?  Yes  No
- Are you afraid of the dark or going to sleep?  Yes  No
- Do you awaken during the night or in the morning with feelings of fear, anxiety, worry, depression, unhappiness, irritability, or confusion?  Yes  No
- Do you tend to lie awake at night with thoughts racing through your mind?  Yes  No
- Do you sleep walk?  Yes  No
- Do you talk in your sleep?  Yes  No
- Do you grind your teeth during sleep?  Yes  No
- Do you wake up with pain in your jaw?  Yes  No
- Are you bothered by itching sensations during the night?  Yes  No
- Have you ever been told that you make rolling/rocking movements in your sleep?  Yes  No
- Do you fall out of bed?  Yes  No
- Do you eat or drink anything or take any medications during the night or after going to bed?  Yes  No
- if so what? \_\_\_\_\_
- Do you usually sleep with a bed partner?  Yes  No
- Are you awake at night because of your bed partner? (because of your partners noise and movement)  Yes  No
- Are you awake during the night because some other person or animal requires assistance?  Yes  No
- Are you awake at night because of noise, heat, cold or light?  Yes  No
- Do you rely on caffeine (coffee, tea, etc) to stay awake during the day?  Yes  No
- Do you feel physically fatigued during the day even when you are not sleepy?  Yes  No
- Is your daytime performance in work or recreation less efficient than you would like it to be?  Yes  No
- Do you yawn very frequently during the day?  Yes  No
- Do you feel distracted and unable to concentrate during the day?  Yes  No
- If you take stimulants do you feel your performance is satisfactory when taking them?  Yes  No
- Uncontrollable urge to fall asleep during the day or find yourself falling asleep when you don't want to?  Yes  No
- Have you had any accidents or near accidents when driving a car due to extreme sleepiness or trouble concentrating?  Yes  No
- Do you function poorly in the morning afternoon or evening  Yes  No
- Are you claustrophobic?  Yes  No
- Is your nose commonly congested or stuffy?  Yes  No
- Does your pulse ever beat too fast or too hard (palpitations) during the day or night?  Yes  No
- Have you ever had any head injuries?  Yes  No
- Do you suffer from fainting spells or loss of consciousness during the day?  Yes  No
- Do you feel that interest in sex is less than normal?  Yes  No
- Do you have problems with reaching an orgasm (climax) during sex?  Yes  No
- Women:
- Are your menstrual periods abnormal or irregular?  Yes  No
- Are you pregnant?  Yes  No
- Are you past menopause or are you having menopausal symptoms now?  Yes  No
- Men:
- Do you wake up with penile erections that are painful?  Yes  No
- Do you have problems obtaining or sustaining a penile erection?  Yes  No
- Do you have problems ejaculating?  Yes  No



# LUNG & SLEEP SPECIALISTS OF NORTH TEXAS

Usual bedtime on workdays \_\_\_\_\_ am/pm      Days off \_\_\_\_\_ am/pm  
 How long does it take to go to sleep on workdays? \_\_\_\_\_ minutes      Days off \_\_\_\_\_ minutes  
 Usual time to get up on workdays \_\_\_\_\_ am/pm      Days off \_\_\_\_\_ am/pm  
 How much sleep do you feel you get each night? \_\_\_\_\_ hours  
 Number of awakenings per night \_\_\_\_\_ how long do you stay awake? \_\_\_\_\_  
 Number of trips to the bathroom per night? \_\_\_\_\_  
 How long does it take you to become fully alert and functional in the morning? \_\_\_\_\_  
 If you take naps, how long are they? (including dozing while watching TV, reading, etc.)? \_\_\_\_\_  
 What time of day? \_\_\_\_\_ How many naps per week? \_\_\_\_\_

### Family history of sleep disorder:

Does anyone in your family have sleep problems?

- Husband
- Wife
- Son
- Daughter
- Father
- Mother
- Other \_\_\_\_\_

Does anyone in your family psychiatric problems?

- Husband
- Wife
- Son
- Daughter
- Father
- Mother
- Brother
- Sister
- Other \_\_\_\_\_

Positive airway pressure is the most reliable and cost effective treatment for Obstructive Sleep Apnea. This treatment uses a small machine to produce air flow, pressure and a hose/headgear system that delivers the air to prevent the airway from collapsing during sleep. An open airway allows unrestricted breathing during sleep. Patients have a choice who they want to provide their equipment. If you have a Durable Medical Equipment company please provide Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not filled out by patient please print name and relationship to patient.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize name: \_\_\_\_\_ Fax: \_\_\_\_\_ to release the following information from the medial record of the below mentioned patient:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This information is to be released to:

Lung and Sleep Specialists of North Texas  
1200 Clear Lake Road  
Weatherford, TX 76086  
Phone: 817-594-9993  
Fax: 817-594-9915

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information. At this time I am requesting the following:

- \_\_\_\_\_ Complete records
- \_\_\_\_\_ Records of care from \_\_\_\_\_ to \_\_\_\_\_ only
- \_\_\_\_\_ Records of care concerning the following condition(s)  
\_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ other, specify \_\_\_\_\_

\_\_\_\_\_ I understand that the information disclosed may contain testing or treatment information to mental health, drug and/or alcohol abuse, treatment of sexually transmitted diseases, HIV/AIDS virus.

The purpose of disclosure:

- \_\_\_\_\_ Continued patient care
- \_\_\_\_\_ Personal use
- \_\_\_\_\_ Attorney/Legal
- \_\_\_\_\_ Other Specify \_\_\_\_\_
- \_\_\_\_\_ Insurance

**I understand that you will provide this information with 15 days from receipt of this request (per Medical Practice Act of the Texas Medical Board) and that a fee for preparing and furnishing this information may be charged if records are being release to the patient for personal use.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_