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PATIENT INFORMATION

Patient Name: _____ Pt Sex: _____ Birthday_____
Address: _____ Apt #: _____ Marital Status: _____
City & State: _____ Zip:_____
Home Phone # ( ) - _____ Cell Phone # ( ) - _____
Work Phone # ( ) - _____ Ext: _____
E-Mail Address: _____
Pharmacy Name: _____
Main Cross Streets: _____
Pharmacy Phone # ( ) - _____ Fax # ( ) - _____
Employer: _____
Employer Address: _____
Emergency Contact: _____ Phone # _____
Relationship to Patient: _____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment. Dr. Kakar and the providers of Snoring & Fatigue render only services that, in their professional judgment, are needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE
We accept cash, Discover, American Express, Visa, or Mastercard

I understand that Snoring & Fatigue Center is out of network with all insurance companies and does not help submit claims.

*****PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED*****

Signed: _____ Date: _____

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Snoring & Fatigue
HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a durable medical equipment company that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protected health information be disclosed to obtain approval or authorization.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing or conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Acknowledgment of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative *Name of Personal Representative*

_____ _____

Date *Description of Personal Representative*

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Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

- ☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
- ☐ Spouse _____
- ☐ Child(ren)_____
- ☐ Other_____
- ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

- ☐ my home
- ☐ my work
- ☐ my cell:_____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

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Consent for SMS Text Messages & Email Messages

I give permission to receive text messages and/or email messages from Snoring & Fatigue or others acting on Snoring & Fatigue's behalf. As part of this consent, You represent and warrant the following:

(1) Snoring & Fatigue or others acting on their behalf may send text messages in various formats and with various contents, including but not limited to, text messages about appointment reminders.

(2) You are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.

(3) You are solely responsible for any message and data charges associated with such text messages.

If You do not wish to receive text messages from the Dallas Sleep or others acting on their behalf, You should not sign this form.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

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Patient Name: _____

Date of Birth: _____

Why are you here today? _____

How long have your symptoms been going on for?_____

Which of the following are concerns for you today? (Check ALL that apply)

- ☐ Snoring
- ☐ Obesity/Weight Gain
- ☐ Anxiety
- ☐ Fatigue
- ☐ Excessive Daytime Sleepiness
- ☐ Depressed Mood

History of sleepwalking as a child?
- ☐ Yes
- ☐ No

Bedtime:_____
- ☐ AM
- ☐ PM

Family history of sleep apnea?
- ☐ Yes
- ☐ No

*Wake time: _____
- ☐ AM
- ☐ PM

How long does it usually take you to fall asleep at night? _____

Do you take any medication to help you sleep?
- ☐ Yes
- ☐ No

If yes, what kind and how often? _____

Number of awakenings during the night:____

Trips to the bathroom during the night: _____

How long does it take you to get back to sleep? _____

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Difficulty falling asleep?
- ☐ Yes
- ☐ No

Restless Legs?
- ☐ Yes
- ☐ No

Difficulty staying asleep?
- ☐ Yes
- ☐ No

Do you wake up feeling refreshed in the morning?
- ☐ Yes
- ☐ No

Morning headaches?
- ☐ Yes
- ☐ No

Snoring
- ☐ Yes
- ☐ No

Witnessed Apneas
- ☐ Yes
- ☐ No

Sweating while asleep
- ☐ Yes
- ☐ No

Coughing
- ☐ Yes
- ☐ No

Gasping/Choking for air
- ☐ Yes
- ☐ No

Bedwetting
- ☐ Yes
- ☐ No

Heart palpitations
- ☐ Yes
- ☐ No

Hypertension/high blood pressure
- ☐ Yes
- ☐ No

Chest pain/chest discomfort
- ☐ Yes
- ☐ No

Anxiety
- ☐ Yes
- ☐ No

Depressed mood/irritability
- ☐ Yes
- ☐ No

Difficulty with concentration
- ☐ Yes
- ☐ No

Memory problems
- ☐ Yes
- ☐ No

GERD/reflux/heartburn
- ☐ Yes
- ☐ No

Shortness of breath during the day
- ☐ Yes
- ☐ No

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Drooling
- ☐ Yes
- ☐ No

Dry Mouth
- ☐ Yes
- ☐ No

Teeth grinding/clenching
- ☐ Yes
- ☐ No

Excessive movements during sleep
- ☐ Yes
- ☐ No

Periodic limb movements
- ☐ Yes
- ☐ No

Nightmares
- ☐ Yes
- ☐ No

Sleep walking or Night Terrors
- ☐ Yes
- ☐ No

Acting out dreams
- ☐ Yes
- ☐ No

Body position during sleep
- ☐ Back
- ☐ Side
- ☐ Stomach

Daytime sleepiness
- ☐ Yes
- ☐ No

Fatigue
- ☐ Yes
- ☐ No

Sleepiness with driving
- ☐ Yes
- ☐ No

Motor vehicle accidents related to drowsy driving
- ☐ Yes
- ☐ No

Do you take naps during the day?
- ☐ Yes
- ☐ No

If yes, are the naps refreshing?
- ☐ Yes
- ☐ No

How often do you nap? _____

Any dozing off unintentionally?
- ☐ Yes
- ☐ No

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PAST MEDICAL HISTORY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PAST SURGICAL HISTORY

1. _____
2. _____
3. _____
4. _____

MEDICATIONS (include prescription and over-the-counter)

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

ALLERGY HISTORY (to nay medication or substance)

- ☐ None known
- ☐ Yes

1._____ 2._____

3._____ 4._____

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SOCIAL HISTORY

Caffeine:

_____ # of cups of coffee per day
_____ # of cups or glasses of tea per day
_____ # of cans or glasses of soda per day
_____ # of servings of chocolate per week

Alcohol:

- ☐ None
- ☐ Yes

_____ # of drinks per day
_____ # of days per week

Tobacco:

- ☐ None
- ☐ Yes

_____ # of packs per day
_____ # of years

Recreational Drugs (such as marijuana or cocaine):

- ☐ None
- ☐ Yes

If yes, which ones?_____

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed

Occupation:_____

Children:

- ☐ No
- ☐ Yes How Many?_____

Pets:

- ☐ No
- ☐ Yes How Many?_____

Do you have any children or pets that sleep in your bedroom?:

- ☐ No
- ☐ Yes

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FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

- ☐ High blood pressure/hypertension
- ☐ Heart Disease
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Overweight/obesity
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Chronic insomnia
- ☐ Restless leg syndrome
- ☐ Multiple sclerosis
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep walking

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Review of Symptoms (ROS)

Constitutional
- Loss of Appetite: ☐ Yes ☐ No
- Sweats: ☐ Yes ☐ No
- Fever: ☐ Yes ☐ No
- Fatigue: ☐ Yes ☐ No
- Weight Gain: ☐ Yes ☐ No
- Weight Loss: ☐ Yes ☐ No

Gastrointestinal
- Heartburn/Indigestion: ☐ Yes ☐ No
- Black or Bloody stools: ☐ Yes ☐ No
- Diarrhea: ☐ Yes ☐ No
- Nausea/Vomiting: ☐ Yes ☐ No
- Jaundice: ☐ Yes ☐ No
- Abdominal Pain: ☐ Yes ☐ No

Allergy/Immunology
- Sneezing: ☐ Yes ☐ No
- Runny Nose: ☐ Yes ☐ No
- Itchy Eyes or Nose: ☐ Yes ☐ No
- Hives: ☐ Yes ☐ No

Eyes
- Blurry Vision: ☐ Yes ☐ No
- Double Vision: ☐ Yes ☐ No
- Vision Loss: ☐ Yes ☐ No

Cardiac
- Palpitations: ☐ Yes ☐ No
- Chest Pain: ☐ Yes ☐ No
- Daytime Shortness of Breath: ☐ Yes ☐ No
- Nighttime Shortness of Breath ☐ Yes ☐ No

Skin
- Unusual Moles: ☐ Yes ☐ No
- Rash: ☐ Yes ☐ No
- Dryness: ☐ Yes ☐ No

Endocrine
- Weight Gain: ☐ Yes ☐ No
- Heat Intolerance ☐ Yes ☐ No
- Excessive Thirst ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Cold Intolerance ☐ Yes ☐ No

Respiratory
- Cough: ☐ Yes ☐ No
- Shortness of Breath: ☐ Yes ☐ No
- Wheezing: ☐ Yes ☐ No
- Poor Exercise Tolerance: ☐ Yes ☐ No

Genitourinary
- Bed Wetting: ☐ Yes ☐ No
- Frequent Urination: ☐ Yes ☐ No
- Difficulty Urinating: ☐ Yes ☐ No
- Blood in Urine: ☐ Yes ☐ No

Musculoskeletal
- Stiff/Sore Joints: ☐ Yes ☐ No
- Muscle Pain: ☐ Yes ☐ No
- Red or Swollen Joints: ☐ Yes ☐ No

Ears/Nose/Throat/Mouth
- Hearing Loss: ☐ Yes ☐ No
- Sore Throat: ☐ Yes ☐ No
- Sinus Congestion: ☐ Yes ☐ No
- Hoarseness: ☐ Yes ☐ No

Neurologic
- Weakness: ☐ Yes ☐ No
- Seizures: ☐ Yes ☐ No
- Involuntary Tongue Biting: ☐ Yes ☐ No
- Passing Out: ☐ Yes ☐ No
- Dizziness: ☐ Yes ☐ No
- Headaches: ☐ Yes ☐ No
- Numbness: ☐ Yes ☐ No

Hema/Lymph
- Unexplained Weight Loss: ☐ Yes ☐ No
- Unusual Bleeding/Bruising: ☐ Yes ☐ No
- Swollen Lymph Nodes: ☐ Yes ☐ No

Psych
- Excess Stress: ☐ Yes ☐ No
- Memory Loss: ☐ Yes ☐ No
- Difficulty with Focus/Concentration: ☐ Yes ☐ No
- Hallucinations: ☐ Yes ☐ No
- Nervousness or Anxiety: ☐ Yes ☐ No
- Depressed Mood: ☐ Yes ☐ No

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THE EPWORTH SLEEPINESS SCALE

Name: _____

Date of Birth: _____

Gender (Please Circle): M F

Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your 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	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (i.e. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In the car, while stopped for a few minutes in traffic	_____

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Sleepiness and Driving

Excessive daytime sleepiness (EDS) is the result of many different problems and it can cause impaired human performance. We feel obligated to inform you about EDS because of its potential for increased accidents and injuries.

Driving while you are sleepy is dangerous. There are 100,000 – 200,000 automobile accidents in the US each year due to sleepiness and fatigue. These crashes cost the US economy $12.5 billion, injure 71,000 individuals, and kill 1,500 people each year in the US alone. Sleep problems and EDS lead to 4 – 7 times the normal risk of having an auto or truck accident. Obviously, it is dangerous to be sleepy in any situation that requires complete alertness.

We recommend that you drive only when fully alert. If you become drowsy while driving, you should pull off the road safely and stop driving. Return to driving only when you are clearly awake. Some people find that a brief nap, a brisk walk, or a cup of coffee will help them become more alert.

There are significant legal and social obligations associated with the safe operation of your motor vehicle. You need to inform us if you are unable to follow our recommendations regarding driving and sleepiness.

Share this information with a friend and you may save his or her life.

Please sign and date below indicating that you have read and understand this information.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

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The Dallas Kakar Inventory (DKI)

1.	Has anyone ever told you that you snore?	☐ Yes ☐ No
2.	Has anyone ever told you that you stopped breathing during sleep?	☐ Yes ☐ No
3.	Do you have a history of high blood pressure or hypertension?	☐ Yes ☐ No
4.	Do you have a history of diabetes?	☐ Yes ☐ No
5.	Do you have a history of heart attack or heart disease?	☐ Yes ☐ No
6.	Do you have a history of atrial fibrillation or congestive heart failure?	☐ Yes ☐ No
7.	Do you wake up frequently during the night?	☐ Yes ☐ No
8.	Do you experience heartburn or reflux symptoms?	☐ Yes ☐ No
9.	Do you wake up feeling unrefreshed from sleep?	☐ Yes ☐ No
10.	Do you feel tired or sleep during the daytime?	☐ Yes ☐ No