DENALI HEALTHCARE SPECIALISTS

NEW PATIENT REGISTRATION

PATIENT INFORMATION			
Last Name:	First Name:		Middle Initial:
Social Security Number:	Date of Birth:	Age:	Gender: ☐ M ☐ F
Address:			
Phone:	Alternate Phone:		
E-mail Address:	Marital Status: ☐Single ☐Married ☐Other _____		
Employer:	Occupation:		
Employer's Address:			

GUARANTOR / RESPONSIBLE PARTY (If different from above)		
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Address:		
Email Address:	Phone:	
Employer / Employer's Address:		
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other _____		

CONTACTS	
Emergency Contact:	Relationship:
Phone:	Alternate Phone:
Primary Care Physician:	Phone:
Referring Physician:	Phone:

INSURANCE / POLICY HOLDER INFORMATION	**(Please present insurance cards to receptionist.)**
Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy ID #:	Policy ID #:
Group #:	Group #:
Policy Holder:	Policy Holder:
Social Security #: Date of Birth:	Social Security #: Date of Birth:
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐ Child ☐Other	Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐ Child ☐Other
Tertiary Insurance Company:	
Policy ID:	Group #:
Policy Holder:	Social Security # Date of Birth:
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Child ☐Other	

Denali Healthcare Specialists complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

I, the undersigned, authorize Denali Healthcare Specialists to provide medical services to me as necessary. I also permit Denali Healthcare Specialists to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

For services rendered, I assign to Denali Healthcare Specialists all medical benefits, if any, otherwise payable to me by my insurer. I authorize release of any and all information and documents to third parties to process claims submitted on my behalf and to secure payment of medical benefits. I understand that I am responsible for amounts not covered by insurance such as the deductible, copayment, coinsurance and any unpaid balance. If I do not have insurance, I acknowledge that I am obligated to pay the full amount at the time of service. With or without insurance, I understand that I am ultimately responsible for all charges incurred.

_____ _____

Signature of Patient or Responsible Party *Date*

DENALI HEALTHCARE SPECIALISTS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Denali Healthcare Specialists is required by law to protect the privacy and confidentiality of your health-related information. We are also required to provide you with this Notice about our privacy practices, our legal duties, and your rights concerning your health-related information. We are obligated to abide by the terms of this Notice. Our Notice of Privacy Practices became effective on April 14, 2003 and remains in effect until replaced.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are several ways in which your physician, our office staff and others outside of our office involved in your care are permitted to use and disclose your protected health information without your written authorization. Protected health information ("medical information") is any individually identifiable health-related information that may identify you and that relates to your past, present or future physical or mental health or condition, health care services provided to you, or payment for health care services rendered. The following list describes different ways that we are permitted to use and disclose your protected health information without your authorization; however, this list is not meant to be exhaustive.

TREATMENT. We may use and disclose your medical information to provide, coordinate, or manage your health care. For example, we may request that your primary care physician share information with us and we may provide information about your condition to your primary care physician.

PAYMENT. We are permitted to use and disclose your medical information to obtain payment from your health insurer for services rendered. For example, we may be required to disclose information about you to your health plan to obtain prior approval to perform certain procedures and to seek payment for services rendered.

HEALTH CARE OPERATIONS. We may use and disclose your medical information for health care operations. Health care operations include: healthcare quality assessment and improvement activities; reviewing and evaluating the competence, qualifications and performance of our health care professionals; training programs for our health care professionals; accreditation, certification, licensing and credentialing activities; medical records review, audits, and legal services; business planning, development, management and administrative activities.

We are also permitted to use and disclose your medical information without your prior approval when authorized and required for the following public health and benefit activities: 1) for public health, including to report disease and vital statistics, child and adult abuse and neglect, and domestic violence; 2) to avert a serious and imminent threat to public health or safety; 3) for health care oversight, for example relating to investigations, inspections, audits and surveys by state insurance commissioners, licensing and peer review authorities, and fraud and abuse agencies; 4) for research; 5) to comply with FDA regulations regarding FDA-regulated products or activities; 6) to comply with OSHA or similar state laws regarding work-related illnesses or injuries; 7) to comply with workers' compensation laws and similar programs; 8) in response to court and administrative orders, subpoenas, warrants, summons and other lawful processes; 9) to report criminal activities to law enforcement officials; 10) in response to requests by military command authorities; 11) for lawful intelligence, counterintelligence, and national security activities; 12) in response to correctional institutions and law enforcement officials regarding persons in lawful custody; 13) in response to coroners, medical examiners, funeral directors, and organ procurement organizations; and 14) disclosures otherwise specifically required by law.

We may disclose your medical information to a family member, friend or any other person involved in your care or responsible for payment of your care but will disclose only the information that is relevant to their involvement. We will provide you with an opportunity to object to these disclosures, unless you are not present or incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interests under the circumstances.

We may also use and disclose your medical information to contact you to remind you of scheduled appointments and to inform you of treatment alternatives or health-related products or services that may be of interest to you.

In any other situation not described above, we will not use and disclose your medical information without your express written authorization. Uses and disclosures of your medical information for marketing and fundraising purposes and uses and disclosures that constitute sales of medical information about you will only be made with your signed permission. You have the right to opt out of receiving fundraising communications.

If you sign an authorization to disclose your protected health information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

PATIENT'S RIGHTS

With respect to your protected health information, you have certain rights:

- You have the right to inspect and obtain an electronic or paper copy of your medical record and other health-related information with limited exceptions.
- You have the right to request that we contact you with confidential communications in a specific way. For example, you may request that we communicate with you through an alternate address or phone number or that we mail confidential communications to you in a closed envelope rather than postcard.
- You have the right to request that your protected health information be amended if you believe it is incorrect or incomplete. If we deny your request, you have the right to file a statement of disagreement with us. Upon receipt of your statement, we will prepare and provide you with a rebuttal to your statement within 60 days.
- You have the right to request that we not use or share your protected health information with any party, including family or friends, regarding your treatment, payment of services, or our healthcare operations. If you pay in full for an item or service, you have the right to request that we not share your medical information with your insurer. Your request must state the specific restriction and to whom the restriction applies. Except in limited circumstances, we are not required to agree to the request if the request is not in your best interests.
- You have the right to request an accounting of all uses and disclosures of your protected health information, with the exception of those for your treatment, payment of services, and our health care operations, that we may have made during the six years prior to the date of your request.
- In the event of a breach that may have compromised the privacy or security of your protected health information, you have the right to receive notice of such breach.
- You have the right to obtain a paper copy of this Notice even if you receive this Notice by electronic mail or view it on our web site.

To exercise your rights, please submit your requests in writing to our Office Manager.

We reserve the right to change the terms of this Notice at any time and to make revisions applicable to health-related information that we maintain, including information that we created or received before changes were made.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a written complaint with our Office Manager or with the U.S. Department of Health and Human Services, Office for Civil Rights, at 200 Independence Avenue, SW, Room 509F, Washington D.C. 20201. We support your right to privacy in matters pertaining to your medical information. We will not retaliate against you if you elect to file a complaint under any circumstances.

By signing this form, I acknowledge that I have read and understand the above Notice of Privacy Practices.

_____ _____ /_____ /_____

Signature of Patient or Responsible Party *Date*

DENALI HEALTHCARE SPECIALISTS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996, Denali Healthcare Specialists may not use or disclose your health-related information except as specified in its Notice of Privacy Practices without prior written authorization. To authorize disclosure of your information in the following situations, please complete and sign this form.

PATIENT INFORMATION		
Name:	Date of Birth:	Age:
CLINICAL INFORMATION ☐ I hereby authorize Denali Healthcare Specialists to disclose my clinical information to family members. ☐ I hereby authorize Denali Healthcare Specialists to disclose my clinical information only to the following persons:		
Name:	Relationship to Patient:	
Name:	Relationship to Patient:	
BILLING AND SCHEDULING INFORMATION ☐ I hereby authorize Denali Healthcare Specialists to disclose billing and scheduling formation to family members. ☐ I hereby authorize Denali Healthcare Specialists to disclose billing and scheduling formation only to following persons:		
Name:	Relationship to Patient:	
Name:	Relationship to Patient:	

APPOINTMENT INFORMATION

I hereby authorize Denali Healthcare Specialists to leave appointment reminders for me in the following way(s):

☐ Telephone #:_____ _____ _____ ☐Voicemail ☐Text Message
Home Work Cell

☐ Mailing Address: _____ ☐ Email Address:_____

EMAIL AND TEXT COMMUNICATIONS

Although reasonable means will be used to protect email communications and text messages sent to and/or received from patients, the privacy, security and confidentiality of these messages cannot be guaranteed. Email communications and text messages are at risk in many situations including, but not limited to, the following circumstances.

- Email communications and text messages can be circulated, forwarded, and broadcast to unintended recipients.
- Email communications and texts messages can be intercepted, altered, forwarded or used without authorization or detection; errors can occur in the transmission process.
- Email is indelible. Even after the sender and recipient have deleted copies of the email, back-up copies may exist on a computer or in cyberspace.
- Employers and online services may have the right to inspect and keep communications that pass through their system.
- Email communications are easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Email communications can introduce viruses into a computer system and potentially damage or disrupt a computer.
- Email communications and text messages can be used as evidence in court.

Terms and Conditions of Use of Email Communications and Text Messages

- Email/text communications to and from patients concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because emails are part of the medical record, individuals authorized to access the medical record, such as clinical staff and billing personnel, will have access to the communications.
- Email/text communications may be forwarded internally to staff members and others involved in the patient's care, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other related matters. These communications will not be forwarded to independent third parties without the patient's written consent, except as authorized or required by law.
- Although every effort will be made to read and respond to email/text communications promptly, there is no guarantee that these communications will be read and responded to within any particular time frame. In an urgent or emergency situation, the patient should call their healthcare provider or go to Emergency Room.
- If the patient's email/text communications require or invite a response and the patient has not received a response within a reasonable period of time, it is the patient's responsibility to determine whether the intended recipient received the communication and when the recipient will respond.
- Email/text communications should not be used to communicate sensitive medical information such as that relating to HIV, mental health or substance abuse.
- The patient is responsible for notifying the office staff of any type of information that the patient does not want to be sent by email or text messages.
- Denali Healthcare Specialists is not responsible for loss of information due to technical failures associated with the patient's email or text messaging software or internet service provider.
- In the event that the patient does not comply with the conditions herein, the patient's privilege to communicate by email or text messages may be terminated.

Guidelines for Communicating via Email or Text Messages

- Limit or avoid using an employer's computer or other third-party computer.
- Notify the office staff of any changes to the email address or cell phone number for text messages.
- Insert topic of email communication in the subject line and patient's name in the body of the email.
- Take precautions to preserve privacy and confidentiality by, for example, using screen savers and protecting your computer passwords.
- Exercise caution when using mobile devices in public places where others may eavesdrop on these communications.

☐ I hereby consent to have Denali Healthcare Specialists' staff communicate with me via e-mail or text messages. I understand and acknowledge that Denali Healthcare Specialists cannot guarantee the privacy, security or confidentiality of information transmitted via email or text messaging.

I certify that I have read and understand this form and I voluntarily agree to the uses and disclosures of information as described. Furthermore, I understand that I may revoke this authorization at any time by submitting written notice to Denali Healthcare Specialists.

_____ _____

Signature of Patient or Responsible Party *Date*

If Responsible Party, Relationship to Patient _____

DENALI HEALTHCARE SPECIALISTS

MEDICAL RECORD RELEASE AUTHORIZATION

As required by the Health Insurance Portability and Accountability Act of 1996, Denali Healthcare Specialists may not use or disclose your health-related information except as specified in its Notice of Privacy Practices without your prior written authorization. To authorize disclosure of your health-related information, please complete and sign this form.

Patient's Name:	Date of Birth:	Age:
☐ I Hereby Authorize Denali Healthcare Specialists to Release My Health-Related Information to the Following:		
Person / Agency:		
Address:		
Phone #:	Fax #:	
Description of Specific Information:		
Purpose of Releasing Information: ☐Treatment ☐Billing ☐Legal ☐School ☐Employment ☐Disability Determination ☐ Other: _____		
Effective dates of authorization : ___/___/___ through ___/___/___ ☐ or until further notice is given.		
☐ I Hereby Authorize Denali Healthcare Specialists to Obtain My Health-Related Information from the Following:		
Person / Agency:		
Address:		
Phone #:	Fax #:	
Description of Specific Information:		
Purpose of Obtaining Information: ☐Treatment ☐Billing ☐Legal ☐School ☐Employment ☐Disability Determination ☐ Other: _____		
Effective dates of authorization : ___/___/___ through ___/___/___ ☐ or until further notice is given.		

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
☐ Drug, Alcohol or Substance Abuse Records
☐ Mental Health Records (except Psychotherapy Notes)
☐ HIV / AIDS-Related Information (including Test Results)
☐ Genetic Information (including Test Results)

I certify that I have read this form and agree to the uses and disclosures of information as described. I understand that I have the right to revoke this authorization at any time by submitting written notice to Denali Healthcare Specialists. I also understand that Denali Healthcare Specialists may not condition my treatment, payment, enrollment, or benefits eligibility on my authorization to use or disclose the above information. Furthermore, I acknowledge that any disclosure carries with it the potential for unauthorized redisclosure by the recipient and that the information disclosed may not be protected by federal or state privacy laws.

_____ _____

Signature of Patient or Responsible Party *Date*

If Responsible Party, Relationship to Patient: _____

DENALI HEALTHCARE SPECIALISTS

OFFICE POLICIES

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. We are committed to working closely with you and your primary care physician to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our office and financial policies.

OFFICE HOURS: Normal business hours are Monday through Friday 9:00 A.M. to 5:00 P.M.

EMERGENCY SITUATIONS: In the event of an emergency during office hours, our staff will notify the appropriate healthcare provider and he or she will return your call promptly. If the office is closed, you will be directed to call our on-call physician for emergencies. In severe emergencies, call an ambulance or go directly to the hospital emergency room nearest to you.

APPOINTMENT SCHEDULING: Appointments are scheduled between 9:00 A.M. to 5:00 P.M. Monday through Friday. If you need to cancel or reschedule your appointment, please notify our office during normal business hours at least 24 hours prior to your appointment. It is very important that you arrive for each visit on time in order for you to have adequate time with your provider. If you are more than 10 minutes late or if your new patient packet is not completed, you may be asked to reschedule. Occasionally, the doctor's schedule and hospital emergencies necessitate a change in your appointment. When this occurs, we will do our best to contact you so that you may avoid an extended wait or unnecessary trip.

CANCELLATION POLICY: Please be aware that if you do not notify us to cancel your appointment at least 1 business day in advance of the appointment, you may be charged $125 if you are a new patient, or $35 if you are an established patient, for the missed appointment. Such fees are not covered by health insurance, hence you will be responsible for paying this fee. After three missed appointments without prior notification of cancellation, Denali Healthcare Specialists will no longer provide services to you. Kindly call our office as far in advance as possible to reschedule your appointment.

PRESCRIPTIONS: Prescription refills should be requested during regular office hours. Please have available the name and number of your pharmacy and the name and dose of the medication. You may also have your pharmacy fax us a refill request. Please allow up to 48 to 72 hours for prescription refills.

CONFIDENTIALITY OF MEDICAL RECORDS: Denali Healthcare Specialists is committed to protecting the privacy and confidentiality of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the different ways that we are permitted to use and disclose your protected health information, and your rights to access and control the information. All records that we create or receive concerning your health or medical condition and the services rendered are confidential and cannot be disclosed without your prior written authorization, except as otherwise permitted by law.

RECORDS REQUEST: To authorize the release of your medical information to a specific person or entity, or to request a personal copy of your own medical records, you must submit your request in writing to our Office Manager. By law, we are required to retain your medical records for 7 years. If you request that our staff complete forms on your behalf, such as short-term disability forms or creditor forms, please allow our staff 48 hours to respond to the request. We charge $35 per form.

Denali Healthcare Specialists complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. As a courtesy to you, we will process your claim with your insurance company. Please note that insurance is a contract between you and your insurance company. While we may be the service provider, we are not party to that contract. Not all services are covered benefits in all insurance plans. In some cases, you may be responsible for amounts not covered by insurance such as the deductible, copayment, coinsurance, and any unpaid balance. We will make every effort to verify your insurance coverage prior to any procedures and relay this information to you. If you have any questions or are uncertain as to your insurance coverage, please do not hesitate to contact us for assistance.

PAYMENT OPTIONS

- Insured Patients: We require that you present a current copy of your insurance card to the receptionist at the time of service. Although we may estimate the amount that you and your insurance carrier owe for services rendered, it is your insurance company that ultimately makes the final determination of eligibility and payment. Once your claim is processed by your insurer, any amounts not covered by insurance will be billed to you.
- Private Pay / Uninsured Patients: You are expected to pay the full amount for services rendered at the time of service if: you do not have insurance coverage; your insurance carrier declines to cover the service; Denali Healthcare Specialists is not contracted with your insurer; or you are paid directly by your insurer.

REFUNDS: If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

RETURNED CHECKS: There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to scheduling a new appointment.

ACCOUNT BALANCES: If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past due. Accounts with balances outstanding for 90 days will be referred to a collection agency. If your account is sent to a collection agency, you may be subject to agency fees and penalties.

DISPUTES: Any disputes of your account should be submitted in writing within 30 days of receipt of the monthly statement. You will be notified of the outcome within 14 days of receipt of your submission.

COMPLAINTS AND GRIEVANCES

To file a complaint or grievance, kindly fill out our Complaint Form and submit it to the Office Manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your grievance.

By signing this form, I acknowledge that I have read and understand Denali Healthcare Specialists' office and financial policies.

_____ _____/_____/_____

Signature of Patient or Responsible Party *Date*

_____

If Responsible Party, Relationship to Patient

DENALI HEALTHCARE SPECIALISTS

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT'S RIGHTS

- Patient has the right to considerate and respectful care from all healthcare providers.
- Patient has the right to impartial access to care regardless of race, gender, age, religion, national origin, cultural, socio-economic, or educational background, physical handicap, or ability to pay.
- Patient with limited English proficiency has the right to language assistance services, free of charge. Patient with physical or mental disability has the right to services that will enable him/her to make informed decisions.
- Patient has the right to emergency care without discrimination due to economic status or payment source.
- Patient has the right to know the identity of the physician who has primary responsibility for coordinating his/her care and identity and professional relationships of other physicians and healthcare providers who will be providing services.
- Patient has the right to receive as much information as necessary to make informed decisions regarding his/her treatment, including information pertaining to the diagnosis, treatment, risks and benefits of treatment, prognosis, plan for follow-up care, unanticipated outcomes of care, reasonable alternatives to proposed care, and consequences of non-treatment. The information relayed to the patient should be accurate, relevant, timely, and easily understandable.
- Patient has the right to discuss and request additional information relating to specific procedures and/or treatments, including their associated risks and benefits, and alternative procedures and treatments.
- Patient has the right to accept or refuse treatment, except as otherwise provided by law, and to be informed of the medical consequences of refusing treatment.
- Patient has the right to personal privacy and confidentiality of all records and communications regarding his/her medical care to the extent of the law. Consultations, case presentations, examinations and treatment are confidential. The patient has the right to know the reason for the presence of any individual observing or participating in his/her care.
- Patient has the right to inspect his or her medical record and obtain a copy of the medical record for a reasonable fee; have information explained or interpreted as necessary; request amendment to the medical record if it is not correct, relevant or complete; and receive an accounting of any and all disclosures of his/her protected health information.
- Patient has the right to request information on the existence of business relationships between the healthcare provider and healthcare facilities, educational institutions, or payers that may influence treatment.
- Patient has the right to know if his/her medical treatment is the subject of experimental research and the right to consent or refuse participation in such research projects.
- Prior to treatment, the patient has the right to receive a reasonable estimate of charges for the proposed treatment. After treatment, the patient has the right to receive a reasonably clear and understandable itemized bill and, upon request, to have charges and any financial assistance offered by the facility explained.
- Patient has the right to receive care in a safe setting, free of all forms of abuse or harassment; patient has the right to expect respect for his or her personal property.
- Patient has the right to file a grievance or complaint regarding violation of his/her rights or any concerns regarding the quality of care received. To file a complaint, patient must submit in writing the Complaint Form to the Office Manager. Within 14 days of submission of the form, the patient will receive written notice of the steps taken on his/her behalf to investigate the grievance, the results of the investigation, and actions taken to resolve the complaint.

Denali Healthcare Specialists complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

PATIENT'S RESPONSIBILITIES

- Patient is responsible for providing, to the best of his or her knowledge, accurate and complete information concerning his/her medical history, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- Patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
- Patient is responsible for reporting whether or not he or she comprehends the contemplated course of action and what is expected of him/her.
- Patient is responsible for following the recommended plan of treatment, including following the instructions of nurses and other healthcare professionals who carry out the physician's orders.
- Patient is responsible for keeping his/her appointments and, when he/she is unable to do so for any reason, for notifying the medical office.
- Patient is responsible for his/her actions if treatment is refused or if the healthcare provider's directives are not followed.
- Patient is responsible for assuring that financial obligations for medical services rendered are fulfilled.
- Patient is responsible for adhering to the office rules and regulations pertaining to patient conduct, being considerate of the rights of other patients and office personnel, and respectful of the personal property of other patients and staff and the property of the office facility itself.

DENALI HEALTHCARE SPECIALISTS

SLEEP QUESTIONNAIRE
MEDICAL HISTORY

Name: _____ SSN: _____ Date of Birth: _____

Age: ____ Height: _____ Weight: _____ ☐ Male ☐ Female

Primary MD: _____ Referring MD: _____

This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.

SLEEP QUESTIONNAIRE

CHIEF COMPLAINT(S)

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Fatigue despite adequate sleep ☐ Snoring
☐ Significant daytime drowsiness ☐ Witnessed apnea ☐ Gasping / choking upon awakening
☐ Sleep walking / talking ☐ Night terrors ☐ Acting out dreams ☐ Legs kick / move while sleeping
☐ Morning headaches ☐ Insomnia ☐ Other: _____

HISTORY OF PRESENT ILLNESS

1. How long have you had this problem? ☐ < 1 month ☐ 1-6 months ☐ 6 months-2 years ☐ >2 years
2. Rate the severity of your problem. ☐ Mild ☐ Moderate ☐ Severe ☐ Problem only for others
3. Is your sleep-related problem getting worse? ☐ Yes ☐ No
4. What factors aggravate your symptoms? _____
5. Does your problem have a negative impact on your ……. work performance ☐ Yes ☐ No
   …….sex life ☐ Yes ☐ No
   ……. quality of life ☐ Yes ☐ No
   ……. social activities ☐ Yes ☐ No
6. Do you use any medications or other substances to help you sleep? ☐ Yes ☐ No
   If yes, please list drug/substance(s), dose, frequency, and length of usage.
   _____
7. Do any members of your family have significant sleep-related problems? ☐ Yes ☐ No
   If yes, please explain:
   _____
8. Have you discussed your sleep-related problems with another doctor? ☐ Yes ☐ No
   Doctor's Name: _____ Diagnosis: _____
   Current treatment: _____ Prior treatment: _____

PLEASE RATE HOW OFTEN YOU OR OTHERS NOTE THAT YOU:

	Never	Occasionally	Frequently
Snore	_____	_____	_____
Snore loudly enough for others to complain	_____	_____	_____
Awaken from sleep feeling short of breath, gasping, or choking	_____	_____	_____
Hold your breath or stop breathing while asleep	_____	_____	_____
Experience other breathing problems at night	_____	_____	_____
Wake up with a headache that improves in less than 2 hours	_____	_____	_____
Have dry mouth upon awakening	_____	_____	_____
Sweat excessively at night	_____	_____	_____
Experience heart pounding or irregular heart beats during night	_____	_____	_____
Feel sleepy or tired during the day	_____	_____	_____
Awaken feeling unrested or unrefreshed	_____	_____	_____
Become drowsy while driving	_____	_____	_____
Have motor vehicle accidents due to sleepiness	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____
Become irritable or crabby	_____	_____	_____
Have difficulty concentrating; experience memory impairment	_____	_____	_____
Fall asleep involuntarily, suddenly or in an awkward situation	_____	_____	_____
Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations	_____	_____	_____
Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness	_____	_____	_____
Have nightmares or night terrors	_____	_____	_____
Act out dreams by yelling and swinging arms and legs	_____	_____	_____
Walk or talk while asleep	_____	_____	_____
Do anything else considered “unusual” while asleep	_____	_____	_____
Move, twitch or jerk your legs while asleep	_____	_____	_____
Feel leg restlessness, agitation or discomfort at or before bedtime	_____	_____	_____
If yes: Do you feel an overwhelming urge to move your legs?		☐ Yes	☐ No
Does it happen only in the evening?		☐ Yes	☐ No
Does it only happen when you are relaxed?		☐ Yes	☐ No
Does it get better if you move around or walk?		☐ Yes	☐ No
Does it disturb your sleep or sleep onset?		☐ Yes	☐ No

How often do you experience this feeling? _____

SLEEP HYGIENE

1. Do you often have anxiety around bedtime? ☐ Yes ☐ No
2. Do you have thoughts racing through your mind while trying to fall asleep? ☐ Yes ☐ No
3. Do you sleep better away from home than in your own bed? ☐ Yes ☐ No
4. Are you anxious or upset if you have difficulty falling asleep? ☐ Yes ☐ No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? ☐ Yes ☐ No
6. Do you exercise within 2 hours of your bedtime? ☐ Yes ☐ No
7. Do you watch TV or read in bed before falling asleep? ☐ Yes ☐ No
8. Do you ever nap or rest during the awake portion of your day? ☐ Yes ☐ No

   If yes: How often? _____ times per day; _____ times per week
   How long is your nap / rest? ☐ < one hour ☐ ≥ one hour
   After the nap / rest, do you still feel tired? ☐ Yes ☐ No

9. Check conditions that routinely apply to you: ☐ Sleep alone ☐ Sleep with someone else in bed ☐ Sleep with pet in room/bed ☐ Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: ☐ Heat ☐ Cold ☐ Light ☐ Noise ☐ Bed Partner
    Other: _____

SLEEP HABITS

1. When do you feel your very best? ☐ Morning ☐ Afternoon ☐ Evening
2. Approximately, how many hours do you actually sleep per night? _____
3. What time do you usually go to bed? Workdays: _____ Non-Workdays: _____
4. What time do you usually rise from bed? Workdays: _____ Non-Workdays: _____
5. How long does it usually take for you to fall asleep? _____
6. How many hours of sleep do you need to feel your very best? _____
7. In an perfect world, what would be the ideal hour for you to go to bed? _____
8. In an perfect world, what would be the ideal hour for you to awaken? _____
9. What usually prevents you from quickly falling asleep? _____
10. How many times do you typically wake up during the night? _____
11. What generally causes you to wake up during the night? _____
12. If you wake up during the night, how long do you typically stay awake? _____
13. If you wake up during the night, when do you typically wake up?
    ☐ Soon after falling asleep ☐ In the middle of the night ☐ Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _____

MEDICAL HISTORY

Please check conditions for which you have been diagnosed:

☐ Angina
☐ Congestive heart failure
☐ Coronary artery disease
☐ Arteriosclerosis
☐ Heart murmur
☐ Rheumatic heart disease
☐ Arrhythmia
☐ Hypertension
☐ Stroke
☐ Peripheral artery disease
☐ Other cardiovascular disorders _____

☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sinusitis
☐ Other respiratory disorders _____

☐ Acid reflux
☐ Diverticulitis
☐ Hiatal hernia
☐ Swallowing disorder
☐ Stomach ulcers
☐ Other gastrointestinal disorders _____

☐ Arthritis
☐ Back pain
☐ Osteoporosis
☐ Chronic fatigue syndrome
☐ Fibromyalgia
☐ Autoimmune disorder
☐ Neuromuscular disorder

☐ Diabetes
☐ Sickle cell anemia
☐ Thyroid disease
☐ Cancer

☐ Migraines
☐ Seizures / Epilepsy
☐ Brain infection
☐ Brain injury
☐ Spinal infection
☐ Spinal injury
☐ Nerve injury
☐ Other neurologic disorders _____

☐ Liver disease
☐ Kidney disease
☐ Blood disorder

☐ Depression
☐ Anxiety / Panic attacks
☐ Alcoholism
☐ Drug abuse
☐ Other psychiatric disorders _____

CURRENT MEDICATIONS: Please list all medications that you are currently taking and their dosages:

_____

_____

DRUG ALLERGIES: Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list:

_____

PAST SURGERIES: Please list all operations and the approximate date of the procedure. _____

_____

FAMILY HISTORY: Has anyone in your blood-related family been afflicted with the following conditions:

☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer
☐ Sleep apnea ☐ Narcolepsy ☐ Restless legs syndrome ☐ Sleep walking / talking ☐ Parasomnias

OCCUPATIONAL HISTORY: Occupation: _____ Are you a shift worker? ☐ Yes ☐ No
If yes, please describe work schedule: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children living at home: ☐ No ☐ Yes Ages of children: _____
Others living at home: ☐ No ☐ Yes ☐ Spouse ☐ Parents / Grandparents ☐ Friend
Alcohol consumption: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Alcoholic
Tobacco use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____
Recreational drug use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____

REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

General
- ☐ Fatigue
- ☐ Malaise / lethargy
- ☐ Generalized weakness
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fever / chills

Eyes
- ☐ Vision changes
- ☐ Double vision
- ☐ Discharge
- ☐ Pain
- ☐ Sensitivity to light

Ears, Nose, Throat and Mouth
- ☐ Earache
- ☐ Ringing in the ears
- ☐ Allergies
- ☐ Frequent colds
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sinusitis
- ☐ Toothache
- ☐ Oral ulcers
- ☐ Dry mouth
- ☐ Facial pain
- ☐ Jaw pain
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Swollen glands

Cardiovascular System
- ☐ Chest pain
- ☐ Pain in arm, shoulder, jaw, neck or back
- ☐ Rapid heart rate
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Pain in leg when walking
- ☐ Ankle / leg swelling

Lungs
- ☐ Chronic cough
- ☐ Shortness of breath with mild exertion
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Bloody sputum

Gastrointestinal System
- ☐ Nausea / vomiting
- ☐ Indigestion
- ☐ Acid reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cramps
- ☐ Bloating
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Rectal pain
- ☐ Rectal bleeding

Genitourinary System
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Blood in urine
- ☐ Pelvic / groin pain
- ☐ Genital ulcers

Male:
- ☐ Erectile dysfunction
- ☐ Testicular pain / swelling

Female:
- ☐ Irregular periods
- ☐ Hot flashes
- ☐ Vaginal discharge

Musculoskeletal System
- ☐ Joint pain / swelling
- ☐ Back pain
- ☐ Muscle pain / weakness
- ☐ Leg cramps

Nervous System
- ☐ Headaches / migraines
- ☐ Dizziness / fainting
- ☐ Seizures
- ☐ Tremors
- ☐ Disorientation
- ☐ Lack of coordination
- ☐ Numbness / paralysis
- ☐ Memory loss / impairment

Psychiatric Symptoms
- ☐ Depression
- ☐ Anxiety / panic attacks
- ☐ Hallucinations
- ☐ Delirium
- ☐ Dementia
- ☐ Suicidal ideation

Endocrine System
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Sexual dysfunction
- ☐ Hair loss
- ☐ Excessive sweating

Skin
- ☐ Rashes
- ☐ Bruises
- ☐ Hives
- ☐ Lesions

Patient's Signature _____ Date _____

DENALI HEALTHCARE SPECIALISTS

EPWORTH SLEEPINESS SCALE

Patient: _____ Date: _____

Age: ____ □ Male □ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you haven't 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

It is important that you answer each question as best you can.

SITUATION	**CHANCE OF DOZING (0-3)**
Sitting and reading	_____
Watching TV	_____
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 score:	_____

DENALI HEALTHCARE SPECIALISTS

BED PARTNER QUESTIONNAIRE

Patient: _____ Observer: _____

Relationship of Observer to Patient: _____ Date: _____

Frequency of observations: ☐ Once or twice ☐ Often ☐ Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

☐ Light snoring
☐ Loud snoring
☐ Loud snorts
☐ Pause in breathing (How long? ____seconds)
☐ Choking
☐ Gasping for air
☐ Twitching, moving or kicking of legs
☐ Twitching or flinging of arms
☐ Grinding teeth
☐ Apparently sleeping even if person behaves otherwise
☐ Other _____

☐ Sleep talking
☐ Sitting up in bed not awake
☐ Getting out of bed not awake
☐ Head rocking or banging
☐ Awakening with pain
☐ Becoming very rigid or shaking
☐ Biting tongue
☐ Crying out

If person snores, what makes snoring worse?

☐ Sleeping on back ☐ Sleeping on side ☐ Alcohol ☐ Fatigue

Does snoring sometimes require you or your partner to sleep separately? ☐ Yes ☐ No

Does this person drink alcohol or use street drugs? ☐ Yes ☐ No