Center for Ear, Nose, Throat & Allergy P.C.

FINANCIAL POLICY

Whether you are new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policy. ***Please read this information carefully—front and back sides—sign on the reverse, and turn in to the receptionist.*** We will be happy to give you another copy to keep for your reference.

Registration. At each visit our receptionist will verify and update your demographic information and insurance coverage and may periodically ask you to complete a new registration form to insure our information is accurate. **Please bring your insurance card to each visit**.

Patient responsibility balances. You will be responsible for

- Services not covered by insurance
- Co-pays and balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage that is your obligation)
- Balances that remain unpaid 60 days after they have been filed with your insurance company but we have received no payment or response

Payment in full is expected within 30 days from your first statement advising you of the balance due.

Insurance. We participate in Medicare, Medicaid, and most commercial insurance plans in the central Indiana area but cannot know the details of the coverage and benefits for your policy. Therefore, you will need to be familiar with your policy and know what is required to access medical care. You have to be aware of the following requirements:

- Network participation of providers
- Referral from your primary care physician authorizing your visit with our doctor, done either by a specific form or by a tracking number assigned to your visit. (If your insurance card has a physician's name on it, that physician must authorize your care by a specialist.)
- Co-pay that must be paid each visit
- Annual deductibles that apply
- Specific hospitals, x-ray facilities, and clinical laboratories that must be utilized for any services.

If you are unsure of what you need, contact your insurance representative or primary care physician before your visit. It is your responsibility to advise us of any insurance changes at time of service. Any billing errors resulting in non-payment of claims will be the responsibility of the patient or guarantor.

A further note about Referral Authorizations: If your insurance policy requires this referral, **it is your responsibility to make sure we have authorization prior to being seen by the doctor**. **Unless you have a medical emergency, if we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled.** While this may seem harsh, it is for your protection as much as ours, as some insurance plans will not pay for any tests or treatments that result from an unauthorized initial visit. If you have a second insurance company, please consider whether that insurance company may require prior referral authorization for the services; if so, and none has been obtained, they will deny payment and you will be responsible for the amounts they might have otherwise paid on your behalf.

Self-Pay and Services not covered by insurance. If you do not have insurance or we are not contracted with your insurance plan, you will be expected to pay at the time of service, or, in some instances, prior to service. Not all services are covered benefits by all insurance policies. Some insurance policies arbitrarily select certain services that will not be covered. Non-covered services will be the financial responsibility of the patient and/or guarantor.

Medical Care to Minors. If both parents have insurance, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent/legal guardian who presents a child for care to be the responsible party for payment of services, regardless of financial responsibility established in a divorce decree. Further, care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to whom you give written authorization to present the child for care.

Motor Vehicle Accidents. If your medical condition results from a motor vehicle accident, we will treat your account as any other, i.e., we will consider you—not your auto insurance—to be the responsible party for all fees. If you have health insurance, we will bill the health insurance and look to you for any unpaid balances. It will be up to your health insurance company to obtain reimbursement from either your automobile insurance or that of another party who is held responsible for the accident. If you have no health insurance, you will be considered a Self-Pay patient.

Payment methods. For your convenience, in addition to cash or personal check, we also accept VISA, MasterCard, and Discover cards. Please be aware that checks returned for insufficient funds will result in a $25.00 fee being added to your account

Acknowledgement and Authorization. I have read, understand, and agree to the above policies. Regardless of any insurance I may have, I am ultimately responsible for payment for any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Center for Ear, Nose, Throat & Allergy, P.C. If my account should become delinquent, I agree to pay the costs of collection, including legal fees and court costs.

Signature ✕____ Date________________________
Patient and/or Responsible Party

RELEASE OF MEDICAL INFORMATION

It may be necessary in the course of your medical evaluation and treatment for your physician to review the results of diagnostic tests or procedures, such as lab work or x-rays, ordered by other physicians. In this era of heightened concern about the confidentiality of medical information, we are being asked more frequently for a written authorization from the patient before this information will be released to us.

Authorization. By signing below, you are giving a hospital, clinical laboratory, radiology facility, or other medical provider who has information pertinent to the diagnosis and treatment of the condition for which you have consulted our physicians permission to release that information to Center for Ear, Nose, Throat & Allergy .

Print Patient Name ____ Date of Birth _______________

Signature ✕____ Date____________________
Patient and /or Responsible Party

FINANCIAL INTEREST DISCLOSURE

The Physicians of Center for Ear, Nose, Throat & Allergy P.C. have financial interests in the following entities: Surgery Center of Indianapolis, Surgery Center of Carmel, Indianapolis Regional P.E.T. Scan and Meridian North Imaging Center. As a patient of Center for Ear, Nose, Throat & Allergy P.C. you may be referred to these facilities to receive medical services. You may however, choose to be referred to another health care facility to receive these services.

I acknowledge and understand my patient rights pursuant to Indiana Law HB 1306 and witness it below with my signature.

Signature ✕_______________________________________ Date_________________________
Patient and/or Responsible Party

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. PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of your health information. We also are required by law to tell you how we may use and disclose your health information; your privacy rights in your health information, and our obligations concerning the use and disclosure of your health information

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location and on our website, *www.centadocs.com*, and you may request a paper copy of our current Notice at any time.

Throughout this Notice of Privacy Practices, you may be instructed to contact our Privacy Officer, either by phone or in writing. Written requests or instructions may be mailed to: Privacy Officer, Center for Ear, Nose, Throat & Allergy, P.C., 12188A North Meridian Street, Suite 375, Carmel, IN 46032 or by e-mail to *privacy@centadocs.com*. Questions or concerns may be communicated in writing or by telephoning the Privacy Officer at 317-579-0472.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR SPECIFIC WRITTEN AUTHORIZATION IN THE FOLLOWING CIRCUMSTANCES:

Treatment. Our practice may use your health information to treat you. For example, we might use your health information to order laboratory or other diagnostic tests, schedule surgery, or to write or phone in a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your health information in order to treat you or to assist others in your treatment, including providing your health information to a physician to whom we have referred you for further care. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents.

Payment. Our practice may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members.

Health Care Operations. Our practice may use and disclose your health information in the business operations of our practice. These activities include, but are not limited to, quality assessment reviews, employee reviews, training of medical students, residents, and fellows, and the preparation and recording of your treatment in our practice. An example of the use of your health information for operations is that our practice may contact you and remind you of an appointment.

Other Services. We may use your health information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use your name and address to send you a newsletter about our practice and the services we offer. You may write our Privacy Officer to request that these materials not be sent to you.

Special Circumstances. The following categories describe unique scenarios in which we may use or disclose your health information:

- To public health authorities and health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

- If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization.

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. Unless you instruct us to the contrary, we may leave messages reminding you of an appointment at your home with a relative or on your answering machine and allow your spouse, parent, or child to schedule or change your appointments. To request a type of confidential communication, write the Privacy Officer, specifying the requested method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosure of your health information, write our Privacy Officer and describe in a clear and concise fashion the information you wish restricted; whether you are requesting to limit our practice's use, disclosure, or both; and to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the health information we maintain on you, including patient medical records and billing records. Write the Privacy Officer in order to inspect and/or obtain a copy of your health information. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, write the Privacy Officer. You must provide us with a reason that supports your request for amendment. We may deny your request if it is not in writing or if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the health information kept by or for the practice; or (c) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request a list of any disclosures our practice has made of your health information for reasons other than treatment, payment, or operations or which were not authorized by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer and state a time period for which you are requesting the accounting, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, with the Secretary of the Department of Health and Human Services, or with the Office of Civil Rights. To file a complaint with our practice, write our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Center for Ear, Nose, Throat & Allergy, P.C.

Patient Registration *Office Use Only: Pt#*

PATIENT INFORMATION: Date:

Last Name:	Sex: Birthdate: Age:
First Name**:** Initial:	Marital Status:
Address:	Social Security No:
City/State/Zip:	Occupation: ☐ Fulltime ☐ Part-time
Home Phone:	Employer:
Cell Phone:	Address:
Email Address:	Work Phone:

PERSON RESPONSIBLE FOR PAYMENT: (For minors, person presenting patient for treatment.)

Name:	Relationship to Patient:
Address:	Social Security No.: Birthdate:
City/State/Zip:	Phone: Home Work
Cell Phone:	Email Address:

ALTERNATIVE CONTACT (For minors, please list other parent)

Name:	Relationship to Patient:
Address:	Phone:
City: State: Zip:	Work Phone:
Cell Phone:	Email Address:

REFERRING INFORMATION: How did you learn about us?

Referring Dr:	Family Doctor:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Other: ☐ Insurance Co. ☐ Yellow Pages ☐ Physician Referral Service ☐ Friend/Family ☐ Other:	

PRIMARY INSURANCE COMPANY:	***SECONDARY INSURANCE COMPANY:***
Insur Co:	Insur Co:
Address:	Address:
City/State/Zip:	City/State/Zip:
Plan Info:	Plan Info**:**
Policy Holder:	Policy Holder:
Sex**:** Birthdate:	Sex: Birthdate**:**
Policy Holder Soc Sec No**:**	Policy Holder Soc Sec No:
Employer:	Employer:
Policy No &/or Group No .:	Policy No &/or Group No.:
Patient Relationship:	Patient Relationship:

AUTHORIZATION & ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services or any other insurance company and its agents, any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Center for Ear, Nose, Throat & Allergy, for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and non-covered services. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Patient or Legal Representative Signature: ____ Date: _________________

CENTER FOR EAR, NOSE, THROAT & ALLERGY, P.C.
Scheduling Phone Numbers 317-926-1056 or toll free 800-283-1056

No-Show Policy

Please understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving care.

We ask that you notify our office by 2:00 pm one working day before your appointment if you need to cancel. In the event you cannot keep an appointment for a PET scan, please call Meridian North Imaging Center by 2:00 pm one working day prior to your appointment. We understand that there will be situations that involve medical emergencies or that are weather related. Failure to do so will result in the following charges applied to your account. These fees cannot be billed to your insurance carrier and must be paid before any new appointments can be made for you. Continued no-show/no-call events may result in your dismissal from our practice. Medical care will not be withheld in the event of an emergency.

- $25.00 - Office visit No-Show
- $50.00 - Office procedure No-Show
- $250.00 - PET Scan No-Show scheduled at Meridian North Imaging Center (aka Northwest Radidology). *The reason for this higher fee is that there is a special injection given for PET Scans. The chemical given in the injection must be specially ordered for each test and lasts only one (1) day and cannot be returned. The fee covers the cost of the chemical.*

I have read, understand, and agree to the above policy.

Print Patient Name ______________________________ Date of Birth______________

Signature X____ Date ________________
Patient and/or Responsible Party

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Center for Ear, Nose, Throat & Allergy Notice of Privacy Practices.

Signature____ Date_________________
Patient or Legal Guardian
Relationship to patient: __ Same __ Parent __ Legal Guardian

Print patient name _______________________________Patient Date of Birth_________

PATIENT HEALTH HISTORY
(ENT)

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Patient's Last Name ___________________________First _____________________MI ____ Appointment Date___________

Date of Birth: ________________ SSN#: __________________Ht.: _________Wt.: _______ BP:___________Gender: ☐ M ☐ F

Name of YOUR Pharmacy___________________________ Pharmacy Address _______________________________________

Pharmacy Phone #_______________________ Full Name of Your Primary Care (Family) Physician _______________________

Name of Referring Provider______________________ Reason for Referral ____

HNSA Doctor You Will Be Seeing____

(TAB 1) **PLEASE LIST *ALL MEDICATIONS* CURRENTLY BEING USED (PLEASE PRINT NEATLY)**

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter and herbal medications)
☐ No ☐ Yes If yes, please list below.

Name of Medication	Dosage	How Often Taken
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other
		___Daily ___Twice a Day ___3 Times Daily __Other

(TAB 2) **Are you *ALLERGIC* to *ANY MEDICATION*? ☐ No ☐ Yes If yes, please list below.**

Name of Medication	Type of Reaction
	___Nausea ___Rash ___Short of Breath ___Shock
	___Nausea ___Rash ___Short of Breath ___Shock

(TAB 3) NON - MEDICATION ALLERGIES

Are you ALLERGIC to:

Dust	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock
Mold	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock
Pollen	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock
Latex gloves	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock
Tape	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock
Iodine	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock
Contrast dye	☐ No	☐ Yes	**Type of Reaction** ___Nausea ___Rash ___Shock

Have you had any allergy testing? ☐ No ☐ Yes (if Yes) ☐ Skin Test ☐ Blood Test Date: ______________

Results: ____

Have You Ever Taken Allergy Shots? ☐ No ☐ Yes (if Yes) Date Started: __________ Date Completed: ______

(TAB 4) PAST HEALTH **Ever been *DIAGNOSED* with any major health problem? Mark the appropriate items.**

CANCER: ☐ **Yes** Type_________Year: ________

HEAD and FACE
Migraine headache ____________________ ☐ **Yes**

EYES
Dry Eyes____________________________ ☐ **Yes**
Glaucoma ____________________________ ☐ **Yes**

EARS
Chronic or frequent ear Infections________ ☐ **Yes**
Hearing loss from aging ________________ ☐ **Yes**
Hearing loss, unknown cause_____________ ☐ **Yes**

NOSE and SINUSES
Nasal Allergies_________________________ ☐ **Yes**
Nasal Polyps___________________________ ☐ **Yes**
Recurrent Sinusitis_____________________ ☐ **Yes**

MOUTH and THROAT
Recurrent Tonsillitis____________________ ☐ **Yes**
Sleep Apnea__________________________ ☐ **Yes**
TMJ Disorder__________________________ ☐ **Yes**

HEART & BLOOD VESSELS
Heart Attack__________________________ ☐ **Yes**
Heart Disease__________________________ ☐ **Yes**
High Blood Pressure____________________ ☐ **Yes**

LUNGS & RESPIRATORY
Asthma ______________________________ ☐ **Yes**
Emphysema __________________________ ☐ **Yes**
Pneumonia___________________________ ☐ **Yes**
Tuberculosis_________________________ ☐ **Yes**

Are you pregnant? ____________________ ☐ **Yes**

STOMACH & DIGESTIVE
Cirrhosis or enlarged liver ______________ ☐ **Yes**
Hepatitis (Type A, B, or C)______________ ☐ **Yes**
Reflux_______________________________ ☐ **Yes**
Stomach ulcer ________________________ ☐ **Yes**

KIDNEY & URINARY TRACT:
Prostate Enlargement __________________ ☐ **Yes**
Renal Failure ________________________ ☐ **Yes**

BONES, JOINTS, and MUSCLES
Arthritis, unspecified____________________ ☐ **Yes**

SKIN:
Eczema _____________________________ ☐ **Yes**

BRAIN & NERVOUS SYSTEM:
Epilepsy _____________________________ ☐ **Yes**
Multiple sclerosis ______________________ ☐ **Yes**
Stroke _______________________________ ☐ **Yes**

MENTAL and EMOTIONAL HEALTH
Anxiety_______________________________ ☐ **Yes**
Depression ___________________________ ☐ **Yes**

GLANDS, HORMONES, & SUGAR CONTROL
Diabetes, unknown type__________________ ☐ **Yes**
Thyroid Deficiency _____________________ ☐ **Yes**
Thyroid Excess ________________________ ☐ **Yes**

BLOOD & LYMPH NODES
Hemophilia ___________________________ ☐ **Yes**
Von Willebrand's Disease_______________ ☐ **Yes**

IMMUNE & INFECTIOUS
HIV _________________________________ ☐ **Yes**
Lupus _______________________________ ☐ **Yes**

(TAB 5) SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **Yes** ☐ **No**
If **yes**, please list what sort of problems. ____

Have you ever had any of the following SURGERIES? ☐ **No** If **YES**, mark any of the following you have had:

EARS
Ear Tubes______________ ☐ **Yes Year** _________
Replace / repair of ear drum (Tympanoplasty)
or mastoidectomy ☐ **Yes Year**________

NOSE and SINUSES
Nasal fracture repair______ ☐ **Yes Year** ________
Nasal polypectomy________ ☐ **Yes Year** ________
Nasal Septoplasty________ ☐ **Yes Year** ________
Sinus Surgery___________ ☐ **Yes Year** ________

MOUTH and THROAT
Adenoidectomy___________ ☐ **Yes Year** _______
Tonsillectomy ____________ ☐ **Yes Year** _______

NECK
Remove Parathyroid Glands___ ☐ **Yes Year** ______
Remove Thyroid Gland________ ☐ **Yes Year** ______
Non-Thyroid Cancer Surgery___ ☐ **Yes Year** ______

HEART AND BLOOD VESSELS
Angioplasty________________ ☐ **Yes Year** ______
Bypass____________________ ☐ **Yes Year** ______
Carotid Endarterectomy______ ☐ **Yes Year** ______
Pacemaker Insertion________ ☐ **Yes Year** ______

LUNG AND CHEST
Esophagus Removal________ ☐ **Yes Year** ______
Lung Removal _____________ ☐ **Yes Year** ______

OTHER SURGERIES NOT LISTED ____ **Year** ____________

Have you been hospitalized for a MEDICAL ILLNESS before? ☐ **No** ☐ **Yes**
If **yes**, list hospitalizations, the reason for admission, and the approximate date(s) of admission. ____________________

(TAB 6) SERIOUS INJURIES
Have you ever had a serious injury such as head, neck, back, or other injury? ☐ **No** ☐ **Yes**
If **yes**, list and describe the type of injury and when it occurred____

(TAB 7) IMMUNIZATIONS ☐ **Up to date** ☐ **Incomplete**

(TAB 8) FAMILY HISTORY ☐ **Not known**

Anesthesia Problems: ☐Mother ☐Father ☐Brother ☐Sister

Head and Face:
Headache ☐Mother ☐Father ☐Brother ☐Sister

Ears:
Hearing Loss before age of 20
☐Mother ☐Father ☐Brother ☐Sister
Hearing Loss after age of 20
☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels:
Heart Disease ☐Mother ☐Father ☐Brother ☐Sister
High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister

Lungs and Respiratory:
Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister
Asthma ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:
Stroke ☐Mother ☐Father ☐Brother ☐Sister

Glands, Hormone, Sugar Control:
Diabetes (age of onset unknown).
☐Mother ☐Father ☐Brother ☐Sister

Blood & Lymph Node problems:
Bleeding/clotting prob.
☐Mother ☐Father ☐Brother ☐Sister

Cancer – TYPE _____
☐Mother ☐Father ☐Brother ☐Sister

(TAB 9) SOCIAL HISTORY
☐ **Check here if you are retired. What is or was your occupation?** __________________**Marital Status** _________

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes** **If yes, please complete the following:**

Type of Tobacco	From year:	To year:
Cigarettes per day:		
Other: (list type)		

Have you ever used alcohol in any form? ☐ **No** ☐ **Yes** **If yes, please complete the following:**

Type of Alcohol	From year:	To year:
Beers per week:		
Wine glasses per week:		
Other: (list type)		

Are you exposed to second-hand smoke? ☐ **Yes** ☐ **No**

Have / do you use other drugs? ☐ **Yes** ☐ **No** **If yes, please list type:**___________________________________

Caffeine use: ☐ **None** ☐ **1 cup/day** ☐ **2-3 cups/day** ☐ **4 or more cups/day**

(TAB 10) REVIEW OF SYSTEMS: MARK any problems you have or have recently had in the following areas.

General Health
☐ **No** ☐ **Yes** (☐ fatigue, ☐ fever, ☐ unintentional weight loss,☐ unintentional weight gain)

Eyes
☐ **No** ☐ **Yes** (☐ dry, ☐ loss of vision ☐ sensitivity to light)

Ears
☐ **No** ☐ **Yes** (☐ ear pain; ☐ ear infection; ☐ hearing loss, ☐ ringing in ears)

Nose and Sinuses
☐ **No** ☐ **Yes** (☐ congestion; ☐ frequent colds, ☐ frequent nose bleeds, ☐hay fever; ☐ sinus drainage)

Mouth and Throat
☐ **No** ☐ **Yes** (☐ change in voice, ☐ snoring, ☐ sore throats ☐ trouble swallowing)

Heart and Blood Vessels
☐ **No** ☐ **Yes** (☐ chest pain, ☐ irregular heart beat)

Lungs and respiratory system
☐ **No** ☐ **Yes** (☐ frequent productive cough, ☐ shortness of breath, ☐ wheezing)

Stomach and digestive system
☐ **No** ☐ **Yes** (☐ abdominal pain, ☐ heartburn, ☐ frequent nausea,☐ painful swallowing, ☐ frequent vomiting)

Skin
☐ **No** ☐ **Yes** (☐ frequent fever blisters/cold sores, ☐ rash)

Brain and nervous system
☐ **No** ☐ **Yes** (☐ change in smell or taste, ☐ difficulty with balance, ☐ numbness, ☐ seizures, ☐ weakness)

Mental and Emotional health
☐ **No** ☐ **Yes** (☐ nervous (anxiety), ☐ sad thoughts more than usual (depressed))

Blood and lymph nodes
☐ **No** ☐ **Yes** (☐ bleeds excessively after injury**,** ☐ bruise easily)

Allergies, infections, immune system
☐ **No** ☐ **Yes** (☐ frequent sneezing, ☐ hives, ☐ unusual infections)

History of Syndrome (Genetic Disease)
☐ **No** ☐ **Yes** If yes, please name: ____

Please list any other physicians involved in your care:

Physician Name______________________________ **Physician Name**______________________________
Phone Number______________________________ **Phone Number**______________________________
FAX Number_________________________________ **FAX Number**_________________________________

Physician Name______________________________ **Physician Name**______________________________
Phone Number______________________________ **Phone Number**______________________________
FAX Number_________________________________ **FAX Number**_________________________________

Patient's Signature: ____ **Date:** _________________

CENTER FOR EAR, NOSE, THROAT & ALLERGY, P.C.
Sleep/Wake Questionnaire

Patient name: ____ **Date:** ________________

In order for us to better understand your sleep problem, please answer the following questions to the best of your ability. If available, please ask your bed partner or observer for input.

Presenting problem:
Please briefly describe your sleep problem.

How long have you had this problem?

Has it changed in recent years? ☐ **Yes** ☐ **No** If so, how?

Who referred you to us? ____

Previous sleep study
Have you ever had a sleep study (polysomnogram)?
□ **No,** please skip to the next question.
□ **Yes,** Institution or sleep laboratory name: ____
Date: ________________ Results: ____
Please arrange for a copy to be sent to us, if possible.

Previous treatment
Please list any previous treatment, whether prescribed or performed by a physician, or just tried on your own.

Sleep history

	Work days	**Weekends**
Average sleep schedule during the week:		
Go to bed at what time?	_______ a.m. p.m.	_______ a.m. p.m.
Get up at what time?	_______ a.m. p.m.	_______ a.m. p.m.
Does your bedtime and/or waking time vary much?	☐yes ☐no	☐yes ☐no
If so, how much?	______________	______________
Average time it takes you to fall asleep	__________ min	__________ min
Average amount of time you sleep each night	__________ hr.	__________ hr.
Average number of times you awaken at night	__________ times	__________ times
How do you awaken?	____ spontaneously ____ alarm clock ____ other	____ spontaneously ____ alarm clock ____ other
Do you use a snooze alarm?	☐yes ☐no	☐yes ☐no
Do you return to bed after arising?	☐yes ☐no	☐yes ☐no
Do you take naps?	☐yes ☐no	☐yes ☐no
If yes, how many times per day?	__________ times	__________ times

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The following is a list of symptoms that may be experienced by people with sleep disorders. Please mark all those symptoms that you have experienced.

- ☐ Complaints from others about your snoring
- ☐ Bed partner sleeps in another room because of your snoring
- ☐ Loud snoring when sleeping on your back
- ☐ Loud snoring when sleeping on your side
- ☐ Loud snoring even when sitting up

- ☐ Stop breathing during sleep
- ☐ Choke or gasp during sleep
- ☐ Awaken with a choking or gasping sensation
- ☐ Awaken with heart beating faster than usual
- ☐ Awaken feeling frightened
- ☐ Awaken frequently during the night

- ☐ Unusual movements while asleep
- ☐ Sweating during the night
- ☐ Difficult nasal breathing during the night
- ☐ Dry mouth upon awakening
- ☐ Headaches upon awakening

- ☐ Awaken feeling tired and unrefreshed
- ☐ Feel exhausted despite sleeping many hours
- ☐ Unable to get good quality sleep
- ☐ Fight sleepiness during daily activities
- ☐ Difficulty staying alert when required to
- ☐ Fall asleep at the wrong times
- ☐ Decreased concentration
- ☐ Forgetfulness

- ☐ Difficulty getting to sleep
- ☐ Often takes more than 30 minutes to fall asleep
- ☐ Wake up at night and can't get back to sleep
- ☐ Wake up early and can't get back to sleep
- ☐ Need to use sleep aids
- ☐ Unable to sleep at all
- ☐ Get only 3-4 hours of sleep on most nights
- ☐ Difficulty sleeping away from home

- ☐ "Creeping crawling" sensation of legs before sleep
- ☐ Leg twitches during sleep

- ☐ Wake up feeling paralyzed and unable to move
- ☐ Sudden body weakness brought by strong emotions
- ☐ Sudden buckling of the knees brought by strong emotions

- ☐ Seeing things when trying to sleep
- ☐ Hearing voices or noises when going to sleep
- ☐ Talking while asleep
- ☐ Walking while asleep
- ☐ Eating during the night
- ☐ Grinding teeth while asleep
- ☐ Often recall your dreams
- ☐ Disturbing dreams

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Daytime sleepiness
The following questions relate to your level of tiredness. How likely are you to doze off or fall asleep in these situations? Use the following scale to choose the most appropriate answer for each situation:

0= would **never** doze | **2**= **moderate** chance of dozing
1=**slight** chance of dozing | **3**=**high** chance of dozing

Chance of dozing	Situation
_______	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 the traffic

_______ **Total**

Are you bothered by sleepiness under other circumstances? ☐**Yes** ☐**No**
If Yes, describe: ____

Have you been in a car accident due to falling asleep at the wheel? ☐**Yes** ☐**No** ☐**Near miss**
If Yes, describe:____

Have you had other types of accidents because of sleepiness? ☐**Yes** ☐**No**
If Yes, describe: ____

Reviewed by____Date_____________________
Physician