K.C. PULMONARY ASSOCIATES

PULMONDARY DISEASES, CRITICAL CARE & SLEEP MEDICINE

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PATIENT'S NAME: _____

ADDRESS _____

CITY, STATE, ZIP CODE: _____

TELEPHONE: HOME _____ CELL: _____ WORK: _____
BIRTH DATE:_____AGE:_____SEX:_____SOCIAL SECURUTY #_____
MARITAL STATUS: S M D W
PATIENT EMPLOYEDBY: _____OCCUPATION: _____
BUSINESS ADDRESS _____

PERSON WHO REFERRED YOU_____

Name of PHYSICIAN: _____

PHONE _____ ADDRESS: _____

PRIMARY INSURANCE _____EFFECTIVE DATE_____

POLICY # _____GROUP# _____

PRIMARY INSURED'S NAME_____ BIRTH DATE: _____

RELATIONSHIP TO INSURED_____

SECONDARYINSURANCE_____EFFECTIVEDATE_____

POLICY#_____GROUP#_____

SECONDARY INSURED'S NAME: _____BIRTH DATE:_____

ASSINGMENT AND RELEASE

I authorize KC Pulmonary Associates to release information about me concerning advice; care and treatmentprovidedmetomyinsurancecompany forthepurposeoffilinganinsuranceclaim. Iauthorize paymentof insurancebenefitstobemadedirectlytoKCPulmonaryAssociates. IunderstandthatI am financiallyresponsibleforpaymentofanydeductible,co-insuranceoranybalancenotcoveredbymy insurance.

Furthermore,IauthorizeKCPulmonaryAssociatestoreleasemyrecordstomyprimaryphysicianfor coordination ofmy care unless specified otherwise.

DATE: _____ SIGNATURE_____

8919 Parallel Parkway, Suite 203 Kansas City, KS 66112 (913) 268-5400 Fax (913) 268-5410

PATIENT CONTACT INFORMATION

The HIPAA privacy rule provides the patient with the right to request confidential communication or that communication of Protected Health Information is made by alternative means, such as sending to the correspondence to the individual's office instead of to the individual's· home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
CHECK ALL THAT APPLY:

Home telephone: _____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only

Cell Phone_____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only

Work telephone: _____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only·

Written communication

- ○ OK to mail to Home Address: _____
- ○ OK to mail to my Work/Office Address_____
- ○ OK to Fax to this number_____
- ○ OK to Email to this Address_____

Other

- ○ OK to Share the information with the Following person (s):
- ○ _____
- ○ _____

Person (not living with you) to contact if unable to reach you directly:

Name:_____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

K.C. PULMONARY SLEEP QUESTIONAIRE

Patients Name: _____

Date of Birth: _____

Main sleep complains: _____

Average Bedtime weeks days _____ Weekends _____

Average wake up time (week days) _____Weekends_____

Do you snore? _____

Have you been told regarding stop breathing / gasping at night? _____

How long does it take to fall asleep? _____

How many times do you awake up in the middle of the night? _____

Reasons for Awakenings_____

How long does it take to fall asleep after awakenings? _____

Wake up time: _____

How do you feel upon awakening? _____

Do you Feel tired throughout the day? _____

Do you feel like dosing off during day if relaxed (watching TV/Reading)? __

Do you have restless legs during the day? _____

Do you feel irresistible urge to move your legs at night? _____

Have you been told that you kick legs a lot at night? _____

Have you ever done shift work? _____

If Yes, for How many years? _____

Any Hallucinations at night? _____

Sleep Paralysis at Night? _____

Have you been ever fallen on the ground in response to a joke /laughter? _____

Any nightmares at night? _____

Sleep Walking? _____

Any unusual behavior at night? _____

PRESENT MEDICAL CONDITIONS

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

PAST SURGERY

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

LIST OF MEDICATIONS

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

Drug Allergies: _____

Social History

Have you ever smoked tobacco? _____

If yes, for how many year's before quitting _____

Do you drink alcohol? _____

Have you ever done any drugs? _____

If yes, What Type and for How many years? _____

Epworth Score: _____

Epworth Sleepiness Scale

Name: _____ 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.

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0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	**CHANCE OF DOZING**
1. Sitting and reading	_____
2. Watching television	_____
3. Sitting inactive in a public place (i.e., meetings, theater, etc...)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon if time permits	_____
6. Sitting and Talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car, while stopped, for a few minutes in traffic	_____
Total Score	_____

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CPAP COMPLIANCE

Do you use your CPAP or Bilevel therapy every night? YES NO

Do you use your CPAP or Bilevel therapy all night? YES NO

If no, how many hours per night do you use your machine? _____

*Thank you for your cooperation

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