SLEEP INSTITUTE of NEW ENGLAND

Accredited by the American Academy of Sleep Medicine

History Questionnaire

Name:_____ DOB:_____SSN#_____ Emergency Contact:_____ Emergency Contact #_____	Ht:_____ Wt:_____	Neck Size:_____	Primary care: _____ Pharmacy name:_____ Pharmacy location:_____

Allergies to Medications: Yes ( ) No ( ) if yes, explain: _____

Allergies to environmental agents: Yes ( ) No ( ) if yes, explain: _____

Do you have any of the following medical problems?

Yes ( ) No ( ) Heart disease if yes, explain: _____

Yes ( ) No ( ) Diabetes if yes, explain: _____

Yes ( ) No ( ) High blood pressure if yes, explain: _____

Yes ( ) No ( ) Cancer if yes, explain: _____

Yes ( ) No ( ) Thyroid disease if yes, explain: _____

Yes ( ) No ( ) Lung problems if yes, explain: _____

Yes ( ) No ( ) Kidney problems if yes, explain: _____

Yes ( ) No ( ) Depression if yes, explain: _____

Yes ( ) No ( ) Anxiety if yes, explain: _____

Yes ( ) No ( ) Insomnia if yes, explain: _____

Yes ( ) No ( ) Chronic pain if yes, explain: _____

Yes ( ) No ( ) Other_____ if yes, explain: _____

Have you ever had a thyroid blood test? Yes ( ) No ( ) if yes, how long ago? _____

Prior Surgeries (including oral or nasal surgeries): _____

Are you currently using CPAP or Bilevel Therapy? Yes ( ) No ( ) If yes, how long & what are your current CPAP or Bilevel pressures? _____

List your current medications: prescription, over the counter and herbals (with dosage):

History **Please completely fill in the circles**

Please select all that apply.

O cough
O wheeze
O shortness of breath
O mucous production with cough
O coughing up blood
O chest discomfort/pain
O oxygen use at night
O oxygen use with exertion
O continuous oxygen use
O current smoker
O former smoker
O passive smoke exposure
O hospital stay for lung problems
O have had a breathing tube (intubation)
O sinus problems
O nasal congestion
O post nasal drip
O environmental allergies
O hay fever
O hoarseness
O weight loss
O weight gain
O fever
O chills
O sweats
O dizziness/lightheadedness
O heartburn/indigestion
O leg/ankle swelling
O headaches
O moved to new residence
O had Pulmonary function test within last 2 years
O history of positive skin test for TB
O history of tuberculosis lung infection

Select all that you have in your home

O cat(s)
O dog(s)
O bird(s)
O other animals
O carpet in bedroom
O woodburning stove/heat
O forced hot air heat
O basement

If you checked environmental allergies, please check all triggers that apply

O
O cats
O dogs
O birds
O trees
O grasses
O pollen
O molds
O dust mites
O smoke
O cold air
O humidity
O spring
O summer
O winter
O fall
O all year
O symptoms at work only
O symptoms at home only
O symptoms day and night

Family History

Did your mother, father, brothers, sisters or children have any of the following?

O heart disease O arrhythmias O thyroid problems O lung problems O psychiatric disorders

O sudden death O obesity O sleep disorders O diabetes O stroke

O high blood pressure O tuberculosis

Social History

Marital Status O married O single O divorced/sep O widowed O partnered

Exercise O none O 1-2 days/wk O 3 or more days/wk

Caffeine O none O 1-2 per day O 2-5 per day O more than 5 per day

Employment status O full time O part time O unemployed O student O stay at home parent

O retired

Children at home O Yes O No

Alcohol: O never O social O daily O more than 2 drinks daily

Smoking history: O never smoked O current smoker O prior smoking history

Recreational drugs: O never used O former user O current user

Review of Systems

O night sweats O fatigue O weakness O trouble breathing through nose

O sore throat O change in voice O nasal congestion O nosebleeds

O runny/stuffy nose O sinus infections O ear fullness O heat intolerance

O excessive sweating O cold intolerance O hot flashes O chronic cough

O pain with breathing O shortness of breath lying down O palpitations

O swelling in ankles O abdominal pain O change in bowel habits O joint swelling

O joint stiffness O muscle aches/pains O chronic pain O leg cramps

O tingling/numbness O seizures O memory problems O falls

O unsteady with walking O attention deficit O anxiety

O depression O eating disorder O nighttime urination O sexual dysfunction

O high stress/tension O

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The Epworth Sleepiness Scale

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 = No Chance of Dozing

1= Slight Chance of Dozing

2 = Moderate Chance of Dozing

3 = High Chance of Dozing

Situation	Chance of Dozing
Sitting and reading	
Watching television	
Sitting inactive in a public place	
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	

SLEEP INSTITUTE
of NEW ENGLAND

Welcome to the Sleep Institute of New England!

The following 3 pages are new patient forms that need to be completed by all patients. To save time at your appointment please read through and complete the following forms and bring them with you to your appointment.

If you have been provided with a username and password to access our patient portal it is helpful to fill out the questionnaire and patient information on the portal. This will help our practice prepare for your visit. If you did not get that information and would like to complete the questionnaires on our patient portal, please call our office at 603-347-8810 and request to be web enabled. You will need to provide us with your email address to complete this process.

Thank you for choosing the Sleep Institute of New England we look forward to meeting you.

SLEEP INSTITUTE of NEW ENGLAND

FINANCIAL POLICY FOR THE SLEEP INSTITUTE OF NEW ENGLAND

We are committed to providing you with the best possible care. Our professional fees can be discussed with you at any time. Your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our financial policy, fees or what your responsibility is. All patients must complete this form **before** seeing the provider.

- ***Co-pays are due at the time of the visit.*** *We accept cash, check, Money Order, and all major credit cards*
- *Returned check fee of $75.00 is due upon receipt of a Patient Statement.*
- *We accept most major insurance plans to include Medicare, Aetna, Anthem, Cigna, Harvard Pilgrim, Martin's Point, Tufts, and United, among others.* ***We do not accept any Medicaid plans.***
- ***Balances after insurance determination for co-pays, deductibles and coinsurance are due upon receipt of a Patient Statement****. Patient payment plans will be considered* ***before*** *the service is provided. Balances over 60 days without arrangements made with the Sleep Institute Financial Office are subject to an outside collection effort*
- ***Office visit no-show or cancellations within 24 hours are subject to a $75.00 cancellation fee.***
- ***Overnight sleep studies no-show or cancellations within 24 hours are subject to a $200.00 cancellation fee.***

Insurance Policy

- **We will assist you to receive maximum benefits but we do not guarantee any information we are given from your insurance company. We may verify your insurance benefits and submit your claim to your insurance carrier as a courtesy to you.**
- **You** are ultimately responsible for knowing your insurance benefits to include any deductible, coinsurance and co-pays for diagnostic procedures, which includes sleep studies. If you are not familiar with your coverage, **we highly recommend that you contact your insurance directly prior to any appointments.** Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract.
- ***The account balance is your responsibility whether your insurance company pays or not,* as *pre-estimate of benefits is never a guarantee of payment by your insurance.***
- Prior to your appointment, **please let us know of any insurance changes you may have had since your last visit.**

⇒ **PATIENT INITIALS: _____**

Referral Policy

Many insurance plans require a referral and or authorization for treatment from your Primary Care Physician prior to receiving services. All non-covered services are the financial responsibility of the patient.

If you have a dispute over a balance because your insurance company did not pay in accordance with any kind of pre-authorization, please understand that this dispute is not with our office but is with your insurance company.

This balance is due in full on receipt of a Patient Statement from the Sleep Institute of New England which will be sent to you after insurance company determination of benefits. We will continue any proceedings needed to collect this balance.

⇒ **PATIENT INITIALS: _____**

No Insurance Policy

The Sleep Institute of New England has a patient discount for patients without insurance. Ask the staff for details prior to your appointment if you do not have insurance. Patients without insurance must pay the full amount at the time of service, unless a payment arrangement is approved prior to an appointed service.

By signing below, I authorize that I have read the entire financial policy and I understand and agree to abide by the above policy.

Print Name _____ Date _____ Signature _____

SLEEP INSTITUTE of NEW ENGLAND
1 Little River Road Kingston, NH 03848

Patient consent form

I hereby give my consent for **Sleep Institute of New England** to use and disclose protected health information about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by **Sleep Institute of New England** describes such uses and disclosures more completely.)

By signing this consent, **Sleep Institute of New England**, which utilizes an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that, may contain health related information or healthcare management advice at the telephone number(s) that you have provided, in reference to any items that assist the practice in carrying out treatment, payment and health care operations such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Sleep Institute of New England** may decline to provide treatment to me.

_____initial

Consent to Examination and Treatment: I hereby consent to allow physicians and medical staff of **Sleep Institute of New England** to examine and treat me in connection with my visits to **Sleep Institute of New England.**

_____initial

Financial Responsibility: I understand that I am financially responsible to **Sleep Institute of New England, PLLC** for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. There will be a $75.00 fee for returned checks.

_____initial

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable

SLEEP INSTITUTE of NEW ENGLAND

Anti-Discrimination Notice

The Sleep Institute of New England (SINE) does not discriminate on the basis of disability, race, color, creed, gender, age, sexual orientation, or national origin, in admission to, access to or operation of its programs, services, activities or its hiring or employment practices.

E-Mail Address:

Preferred language

- ☐ English
- ☐ Other _____

Ethnicity

- ☐ Hispanic or Latino
- ☐ NOT Hispanic or Latino
- ☐ No Reply

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other
- ☐ No Reply

1 Little River Road · Kingston, NH 03848
Tel: 603-347-8810 · Fax: 603-347-8811
www.SleepNE.com

SLEEP INSTITUTE of NEW ENGLAND

Patient's name: _____

Date of birth: _____

Facility:
(SLEEP INSTITUTE OF NEW ENGLAND TO FILL OUT THIS SECTION ONLY)

Sleep Institute of New England
1 Little River Road
Kingston, NH 03848
Fax: (603) 347-8811

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, sleep studies, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ **Date:** _____
Patient's Signature