5620 W. Thunderbird Rd. Ste B3
Glendale, AZ 85306
P: 602-206-6262
F: 602-235-0296
sonoransleep.com

Adult Registration Form

Patient Information:

Last name:_____ First Name: _____ Middle name/Initial:_____

Date of Birth:_____ Age:_____ Sex:_____ Social Security Number:_____

Address: _____ City: _____State: _____ Zip code: _____

Cell phone:_____ Home phone: _____☐ same as cell

Email: _____ Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Employer: _____ Current occupation: _____

Ethnicity: _____ Race: _____ Language: _____

Emergency contact Name: _____ Phone:_____Relationship:_____

Primary Care Physician: _____ Phone number:_____

Pharmacy Name: _____ Phone number: _____

Address: _____ City: _____State: _____ Zip code: _____

Preferred contact ☐ email ☐ phone ☐ SMS/text message (*carrier charge may apply*)

EMAIL/SMS and/or Patient Portal Opt in Agreement

We may send a voicemails, emails, text messages (SMS) to you with information regarding your office visit with your consent. This information is only to provide quality care and not shared with anyone. Check below if you would like to opt in to set up appointment reminders, medication refills, access medical records and receive medical records through these communication tools. (This does not apply to controlled medications). You may opt out at any time by notifying us in writing.

☐ **Opt in ☐ I request to decline any technical forms of communication**

Insurance Information: *(Please include a copy front and back)*

Primary Insurance:_____Primary Insured Name:_____ Date of Birth:_____

ID number:_____Group number:_____ Relationship to patient: ☐ self ☐ spouse ☐ other

Insurance Address: _____ City:_____State:_____Zip code:_____

Secondary Insurance:_____Insured Name:_____ Date of Birth:_____

ID number:_____Group number:_____ Relationship to patient: ☐ self ☐ spouse ☐ other

Insurance Address: _____ City:_____State:_____Zip code:_____

Responsible Party/Guarantor:

☐self ☐ other: If other:

Name of Party: _____Relationship: _____ Date of Birth:_____

Address: _____ City: _____State: _____ Zip code: _____

Prescription Refills:

If a refill is required prior to scheduled office visit, refill requests will be handled within 24 hours, unless there is a problem and we will notify you otherwise. Do not wait until you are out of medication before calling your pharmacy for a refill. **Any request for refill made on Friday afternoon will not be made until Monday morning.** Refill requests must be made during office hours. **Refill requests will not be authorized at night or during weekends.**

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Notice of Privacy Practices

The office of Sarah Patel MD PC dba Sonoran Sleep Center is dedicated to protect your "non public personal health information", This notice is to tell you how and why we collect that information, who has access to that information, and your rights regard that information. Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This ensures that the information we collect is correct. We may also ask a doctor or other health care provider who referred you to this practice to give us health information for evaluation and treatment purposes. This benefits you in that we will have prior medical history that has already been obtained by the referring entity. We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance. To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those-entities that need your information to process health care claims and obtain payment for our services have access to your personal health information (PHI). Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your PHI. These entitles are mandated by Law and this practice has no jurisdiction over such entities. Our practice will obtain your written authorization for uses and disclosures that are not covered by this Notice of Privacy Practices or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

We release your information only to those entities who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entitles who need this information for claims processing have access to your PHI. You have the right to inspect your PHI and have the right to amend any errors you may find in your record. if you leave this practice, your PHI will continue to receive the protection outlined in this notice. If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services; Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C., 20201, or phone (202) 619-0257 or toll free (877) 696-6775. All complaints submitted to the practice must be submitted in writing. You will not be penalized for filing a complaint.. This practice reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office and our website. This notice is effective as of January 20, 2020. Notice of Privacy Practice is also available at our website: sonoransleep.com. You are entitled to receive a paper copy of this Notice of Privacy Practices at any time. If you have any questions regarding this Notice of Privacy Practice or the health information privacy policies of this practice, or to obtain a paper copy of this Notice of Privacy Practice, please call us at: (602) 206-6262.

If you intend to request any information regarding your PHI or exercise any rights under this Notice of Privacy Practice, please notify us in writing at: Sonoran Sleep Center, 5620 W Thunderbird Road Ste B3, Glendale, AZ 85306.

I acknowledge that this practice's Notice of Privacy Practice has been made available to me.

Patient/Responsibility party signature: _____ Date: _____

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Patient Financial Responsibility Form

The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care. Your insurance is a contract between you and your insurance company. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding your coverage. This includes all primary, secondary and any tertiary coverage. Patient (or patient's guardian) is responsible for payments of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Co-pays are due at the time of service. Coinsurance and deductibles are due at the time of service. This charge is an estimate of what your insurance carrier covers. Patients may incur, and are responsible for payment of any additional charges, if applicable. This includes any charges that are not covered by any secondary or tertiary insurance. We expect and encourage you to know your insurance benefits, including but not limited to co payments, coinsurance, deductibles and services that are covered or not covered by your carrier. **All out of pocket amounts quoted by Sonoran Sleep Center are estimates. Prior approvals that are received from your insurance company are not a guarantee of payment. The patient (or patient's guardian) is required to provide a copy of your insurance card(s) and photo ID at the time of visit. Additionally, a credit/debit card may be required to be kept on file for guarantee of payment(s) or cancellation fees. A cancellation/no show fee of $100.00 will be charged if you do not notify us at least 24 hours prior to your scheduled consultation or office visit appointment. You must notify us at least 48 hours prior to your scheduled Sleep Study or there will be a $350.00 cancellation fee.** The notification must be business days which are Monday through Friday. Please contact us at (602) 206-6262. Patient statements are mailed monthly.

Payments for invoices that are billed to the patient are due 30 days from receipt of billing. A $50.00 fee will apply if payments are late. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement. A service charge will apply for any payment arrangements.

You are responsible for additional charges for the following copying and distribution of patient medical records: $25.00; forms completion, including but not limited to FMLA forms $25.00. Please allow 10 business days to complete these forms.

Patients who are not covered by health insurance are required to pay for the provided services at the time of service. You may also choose to pay directly for health care services, and if you choose to do you, we will not submit a claim to your insurance company. It is your responsibility for notifying us when you do not wish a claim to be submitted on your behalf.

I, the undersigned, certify that I or my dependent have insurance coverage as indicated above. I assign directly to Sonoran Sleep Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all medical and other necessary to insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care including for securing the payment of benefits. I authorize the use of this signature on all insurance submissions.

I acknowledge that this practice's patient financial responsibility form has been made available to me.

Patient/Responsibility party signature: _____ Date: _____

Telemedicine Patient Consent Form

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to Sonoran Sleep Center providing health care services to me via telemedicine.

All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician. Telemedicine visits may not be available for all conditions, and it is also possible that during or after a telemedicine visit, we may ask you to come to our practice for a face-to-face visit with a clinician if we need to perform certain physical exams that reaches beyond the abilities of telemedicine technologies.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I may revoke my consent in writing at any time by contacting Sonoran Sleep Center. As long as this consent is in force (has not been revoked) Sonoran Sleep Center may provider health care services to me via telemedicine without the need for me to sign another consent form.

Signature of patient/guardian: _____ Today's Date: _____

SLEEP MEDICINE NEW PATIENT QUESTIONNAIRE

Name: _____

Primary care Physician: _____ Referring Physician: _____

What problem causes you to seek our help?_____

CHECK the box for each problem you **CURRENTLY HAVE:**			
Loud snoring	Waking up to urinate	Nightmares	Uncontrollable daytime sleep attacks
Wake up choking/gasping for breath at night	Heartburn at night	Sleepwalking	Feeling sleepy during the day
Witnessed Apnea (*I've been told that I stop breathing when asleep)*	Restless sleep	Sleep terrors	Falling asleep unexpectedly
Awaken un-refreshed	Trouble falling asleep	Tongue biting in sleep	Falling asleep at work or school
Teeth grinding	Trouble staying asleep	Bedwetting	Falling asleep while driving
Nighttime sweating	Waking too early in the morning	Acting out dreams	Recent change in sleep schedule
Morning dry mouth	Racing thoughts when trying to sleep	Feeling paralyzed when falling asleep or waking up	I use sleeping pills to help me sleep
Morning headache	Lying in bed worrying	Hallucinations when falling asleep or waking up	Pain interfering with sleep If yes, where is the pain? _____
Waking up with sore throat	Sleep talking	Sudden muscle weakness when laughing or afraid	Restlessness/discomfort in legs when trying to fall asleep

Have you had the **following medical conditions**? *(Check appropriate boxes)*

HEART DISEASE	**GASTROINTESTINAL**	**NEUROLOGY**	**LUNG DISEASE**	**EAR/NOSE/THROAT**
☐ Heart Failure	☐ Liver disease	☐ Stoke or TIA	☐ COPD/Emphysema	☐ Chronic sinusitis
☐ Heart attack	☐ Acid reflux	☐ Parkinson's Disease	☐ Asthma	☐ Seasonal allergies
☐ Angina	☐ Colitis	☐ Seizure	☐ Pneumonia	☐ Post nasal drip
☐ Atrial fibrillation	☐ Stomach ulcers	☐ Spinal cord injury	☐ Tuberculosis	☐ Nasal surgery
☐ High Blood pressure	**ENDOCRINE**	☐ Head injury/trauma	☐ Other lung disease	☐ Tonsillectomy/ adenoidectomy
MSK	☐ Diabetes	☐ Headaches	☐ Dementia	**SLEEP**
☐ Osteoarthritis	☐ Thyroid disease	☐ Fainting spells	☐ Memory loss	☐ Sleep Apnea
☐ Lupus	**OTHER**		**PSYCHIATRIC**	**UROLOGIC/KIDNEY**
☐ Rheumatoid Arthritis	☐ Cancer Type: _____ Metastatic? Y/N		☐ Depression	☐ Kidney disease
☐ Fibromyalgia	☐ Peripheral vascular disease	☐ Lymphoma/ leukemia	☐ Anxiety	☐ Urologic disease
☐ Spine surgery	☐ HIV	☐ Chronic fatigue	☐ Alcoholism	☐ Enlarged Prostate
	☐ Anemia	☐ Blood clots	OTHER: _____	

Medications you have taken in the **past 6 months:**

Name of drug, Vitamin, or herbal supplement	Dose	Number of pills per day	Taken for what Problem? (If known)	Still taking? Y/N

Reason for Hospitalization or types of surgeries	Date or Year

Typical Sleep Habits:

1. What time do you typically go to bed on **WEEKDAYS**? ____:____am/pm
    a. How long does it take you to fall asleep? _____mins
2. What time do you typically awaken on weekdays? ____:____am/pm
    a. Do you use an alarm clock/wake up call? ☐ yes ☐ no
    b. Do you feel refreshed upon wakening? ☐ yes ☐ no
3. How many times do you awaken on a typical night? _____
4. Do you have difficulty returning back to sleep? ☐ yes ☐ no
5. What time do you typically go to bed on **WEEKENDS/DAYS OFF**? ____:____am/pm
    a. How long does it take you to fall asleep? _____mins
6. What time do you awaken on weekends/Days off: ____:____am/pm
    a. Do you use an alarm clock/wake up call? ☐ yes ☐ no
    b. Do you feel refreshed upon wakening? ☐ yes ☐ no
7. Check typical causes for awakening at night:
    ☐ Snoring ☐ Choking/gasping for air ☐ Full Bladder ☐ Bedroom noise ☐ Headache
    ☐ Nightmares ☐ Worry ☐ Thirst/hunger ☐ Bed partner/kids/pets ☐ Night sweats ☐ Heartburn

    Please list other causes:_____
8. Do you nap ☐ yes ☐ no
    If yes: How often do you nap? _____ times per week?
    What time of the day? _____ How long are your naps? _____
    Do you feel refreshed upon awakening? ☐ yes ☐ no

Have you ever had a sleep study before? ☐ yes ☐ no

If yes: Please indicate where and when you had the study: _____

Do you currently use a CPAP or BPAP machine at home? ☐ yes ☐ no

What are your current pressure settings? _____ cm H_{2O}

Please provide the name of your Home Health Company (DME)_____

What is your occupation?_____

Are you a shift worker? ☐ yes ☐ no If yes: What kind of shift do you work _____

Do you have a family history of **any major diseases and or any sleep disorders**? If yes, please describe:

_____

Current weight_____ Weight 1 year ago_____ Weight at age 20 _____

Please list your current average for each category below:

Tobacco use: ☐ Never ☐ current _____ cigarettes per day _____# years ☐ former smoker ☐ vape

Caffeine: _____ Cups of caffeine (tea or coffee cola) or other caffeinated beverages per day

Alcohol: _____ Cans of beer per day (12 oz) _____ Glasses of wine per day (4 oz) _____ Liquor per day (1-2 oz straight or mixed)

How **LIKELY** are you to **DOZE OFF** or **FALL ASLEEP** in the following situations, in contrast to feeling just tired? **Please check one box per line:**

Never	Rarely	Frequent	Always	
				Sitting and reading
				Watching TV
				Sitting, inactive in a public place (example, 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 lunch without alcohol
				In a car, while stopped for a few minutes in traffic
				Total Score: _____

INSOMNIA

Do you have problems getting to sleep or staying asleep? ☐ yes ☐ no

- **If NO, you may stop here**
- ***If YES, please continue***

Please rate the current (**in the last 2 weeks)** SEVERITY of your insomnia problems:

	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep					
2. Difficulty staying asleep					
3. Problem waking up too early					
4. How SATISFIED or DISSATISFIED are you with you current sleeping pattern?	**Very Satisfied**	**Satisfied**	**Moderately satisfied**	**Dissatisfied**	**Very dissatisfied**
	Not at all	**A little**	**Somewhat**	**Much**	**Very Much**
5. To what extent do you consider your sleep problem to INTERFERE with your daily functioning?					
6. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life? (e.g. ability to function at work/daily chores, memory, mood, etc.)					
7. How WORRIED/DISTRESSED are you about your current sleep problem?					