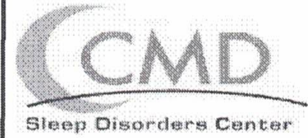
300B. Princeton - Hightstown Road
East Windsor, NJ 08520Suite 205



Name:____________________________ Date of birth: _____/____/_____ Gender: M F

Address:__________________________ City:_____________State:____________ Zip code:_________
Home phone:_____________________________ Work phone:________________________________
Cell phone: ______________________________ Email: __________________________________
Emergency phone:_________________________ Contact person:_____________________________
Soc. Sec. Number:_________________ Marital Status: M S W D
Spouse's name:______________________________ Spouse's date of birth:_______/______/_____

Employment Information

Retired: Yes_______ No________ Date Retired: _______/_______/________
Employer Name :____
Address:____

Insurance information

Please fill in Completely

Primary insurance name:____
Insured Person's Name: ____________________ID#: _________________ Group #:_______________
Secondary insurance name:____
Insured Person's Name:_____________________ID#: _________________ Group #:_______________

Referring Physician Information *(Physician that referred you for sleep study)*

Name: ____
Specialty: ____
Address: ____
City: _____________________________ State:_______________ Zipcode:____________________
Office Phone #:__________________________________ Office fax #:____________________________

Primary Care Physician

Name: ____
Address ____
City: _____________________________ State:_______________ Zipcode:____________________
Office Phone #:__________________________________ Office fax #:____________________________

Please read and sign

I authorize the release of any medical information necessary to process this claim. I also authorize the attending physician to release information concerning my exam and treatment . I consent to treatment for my sleep study at CMD Sleep Center and I am also aware that I am responsible for payments of copays, deductibles and any other fees that my insurance will not cover.

Signature: ___________________________________ **Date:** ________/________/__________

Signature: _____________________________________ **Date:** ________/________/__________
If you are the guardian or P.O. A. sign here

Authorization #: Global: ICD 10 codes:

CONSENT FORM

DATE (MM/DD/YY)________________________________ TIME_____________A.M. / P.M.

I authorize ____ to be performed on
(TYPE OF PROCEDURE)

____ under the direction of
(NAME OF PATIENT)

____
(NAME OF PHYSICIAN)

The nature and purpose of the procedure, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the result that may be obtained.

I authorize administration of such medications as deemed necessary by the physician for the procedure. I consent to the taking of pictures with a camera before my nocturnal polysomnogram recording, and videotaping as a part of the diagnostic study. I hereby give permission to release any medical information in order to file any insurance claims. I also authorize the release of medical information from my physician to any consulting physicians in regards to this procedure. I also assign any benefits paid on my child or me to be paid directly to CMD Sleep Disorders Center. I understand that a separate bill for interpretation may be sent from the interpreting physician.

_________________________________ _________________________________
PATIENT (PARENT I GUARDIAN) WITNESS

_________________________________ _________________________________
DATE DATE

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Billing and Insurance Acknowledgement

Please review and initial that you acknowledge and agree to the following statements.

Medicare Acknowledgement:
I request that payment of authorized Medicare benefits be made either to me or to [Comprehensive Medical Diagnostics, LLC] for any services furnished to me. I authorize any holder of medical information about me to be release to "The Centers for Medicare & Medicaid Services", and its agents any information needed to determine these or the benefits payable for related services. I understand that I will be responsible for any deductible, coinsurance, and non-covered expenses. ___________ (Initials)

Commercial Insurance Acknowledgement:
I request that payment of authorized Health Insurance benefits be made either to me or to [Comprehensive Medical Diagnostics, LLC] for any services furnished to me. I understand that I will be responsible for any deductible, coinsurance, and non-covered expenses. Any payments made to me by my insurance company for services rendered at [Comprehensive Medical Diagnostic, LLC] will be mailed to the sleep lab (address on header). __________ (Initials)

I authorize [Comprehensive Medical Diagnostics, LLC] to release all medical information necessary for processing insurance claims to the insurers on file. I agree these provisions will be in effect until otherwise revoked by me.
__________ (Initials)

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, and etc. I specifically authorize such healthcare providers to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other reports or information regarding my physical condition. __________ (Initials)

Acknowledgement for SELF-PAY:
You have requested that this service to be self-pay because (initial one):
____You have no health insurance.
____You have health insurance, but you do not want your insurance billed and instead want to pay out of pocket.
____ Other (Please Explain): ____

NO SHOW
_____ I understand that sleep lab may charge a $200 "no show" fee in the event that I do not call with at least 24 hours' notice to cancel or reschedule an appointment.

By signing below, I acknowledge that I have read and understand the above information. I confirm that I am the patient, or the patient's duly authorized representative.

Signature of Patient or Legal Representative: ______________________________________ Date: _______________

Print Name: ____ Relationship to Patient: ________________

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Sleep Disorders Health Risk Assessment - Adult

Patient's Name ____
First Middle Last

SLEEP HISTORY

Main Sleep Complaint/Reason for night-time awakenings:

____

____

At what age did this problem begin? _______________

How does this affect your life and daily activities?

____

____

If employed, what are your usual working hours? Start time __________Stop time __________

What time do you usually go to bed and get up on weekdays (or work days)?
______ to bed ______ get up

What time do you usually go to bed and get up on weekends (or days off)?
_______ to bed ______ get up

Section 1 **Insomnia**

Yes	No	
☐	☐	Do you have trouble falling asleep?
☐	☐	Are you bothered by thoughts that keep you from sleeping?
☐	☐	Are you frightened to go to sleep?
☐	☐	Do you feel depressed or sad?
☐	☐	Does it take you more than a half hour to fall asleep?
☐	☐	Do you awaken much earlier in the morning and are unable to fall back to sleep?

Section 2 **Sleep Apnea**

Yes	No	
☐	☐	Do you often feel that you get too little sleep at night?
☐	☐	Are you bothered by sleepy periods during the day?
☐	☐	Do you remember dreaming?
☐	☐	Do you snore, or has someone told you that you snore?
☐	☐	Does the snoring disturb your bed partner or someone else in the house?
☐	☐	Are you bothered by nightmares?
☐	☐	Are you bothered by breathing problems at night?
☐	☐	Do you have unusual behavior during sleep?
☐	☐	Do you usually feel tired or sleepy during the day?
☐	☐	Do you have high blood pressure?
☐	☐	Have you been gaining weight?
☐	☐	Have you been undergoing changes in your personality?
☐	☐	Do you sweat during the night?
☐	☐	Do you feel you have lost interest in sex?
☐	☐	Do you waken gasping for breath in the middle of the night?
☐	☐	Do you have headaches in the morning?
☐	☐	When you have a cold do you find falling asleep more difficult?
☐	☐	Have you ever felt your heart pounding or beating irregularly during the night?
☐	☐	Have you been told that your performance on the job is not up to par?

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Section 3 Narcolepsy

Yes	No	
☐	☐	Do you have difficulty concentrating at school or at work?
☐	☐	Have you fallen asleep at the wheel of a car?
☐	☐	Do you fall asleep during the day?
☐	☐	Have you ever fallen asleep while laughing or crying?
☐	☐	Do your knees get weak if you laugh or get angry?
☐	☐	Have you fallen asleep during physical exertion?
☐	☐	During the day, do you feel dazed as if in a fog?
☐	☐	If you become angry, does your body feel limp?
☐	☐	While falling asleep or awakening, have you experienced vivid dreams?
☐	☐	Soon after falling asleep, have you had nightmares?
☐	☐	Do you often feel that you must fill your day with activity?
☐	☐	No matter how hard you try to stay awake, do you still fall asleep?

Section 4 GERD

Yes	No	
☐	☐	Do you gasp for breath during the night?
☐	☐	Do you awaken in the night coughing?
☐	☐	Are you hoarse in the morning?
☐	☐	Do you awaken with heartburn?
☐	☐	Do you have a chronic cough?
☐	☐	Are you taking antacids routinely on a weekly basis?
☐	☐	Do you have frequent sore throats?

Section 5 Restless Legs/PLMS

Yes	No	
☐	☐	Do you have pain that interferes with your sleep?
☐	☐	Do you awaken with muscle aches?
☐	☐	Do you have muscle tension in your legs, even outside of exercise?
☐	☐	Do you kick in bed at night?
☐	☐	Even though you sleep at night, do you awaken feeling tired?
☐	☐	Have you experienced a sensation of "crawling" or aching in your legs?
☐	☐	At night, do you feel the need to move your legs?

Does anyone in your family have any sleep problems? Yes ______ No ______

Have you been told or do you have any of the following?

Problem	Yes	Time/Wk.	Age of onset	Last occurred
talk while asleep				
walk while asleep				
grit teeth while asleep				
wake up screaming or afraid for no reason				
stop breathing in your sleep				
awaken with heartburn or sour taste				
other				

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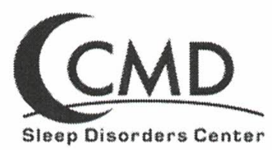


PAST MEDICAL HISTORY

Have you had any of the following:

Surgery	Yes	No	If yes, when?
Tonsillectomy			
Adenoidectomy			
Nasal or sinus surgery			
Vocal cord surgery			
Other surgery			

Any use of prescription or over the counter medications regularly or occasionally?
Yes _____ No _____

If yes, please list by name below:

Name of Medication	Amount	How often	Reason used	How long	Prescribing Doctor

For each of the beverages listed, write the average number you drink per day:

Regular coffee _______ cups/day   Decaffeinated coffee _______cups/day

Tea _______ cups/day   Caffeinated soft drinks _______cups/day

On the average, how many alcoholic beverages do you drink a week? ______________________

On the average, how much tobacco do you smoke? (**Please fill in number per day**).

— Cigarettes/day
— Cigars/day
— Pipe/day
— Chewing Tobacco/day

Do you get regular exercise? Yes_____ No _____ how often_________ time of day __________

What kind ____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ______________

AGE: _______ DATE OF BIRTH: ______________ OCCUPATION: ______________________

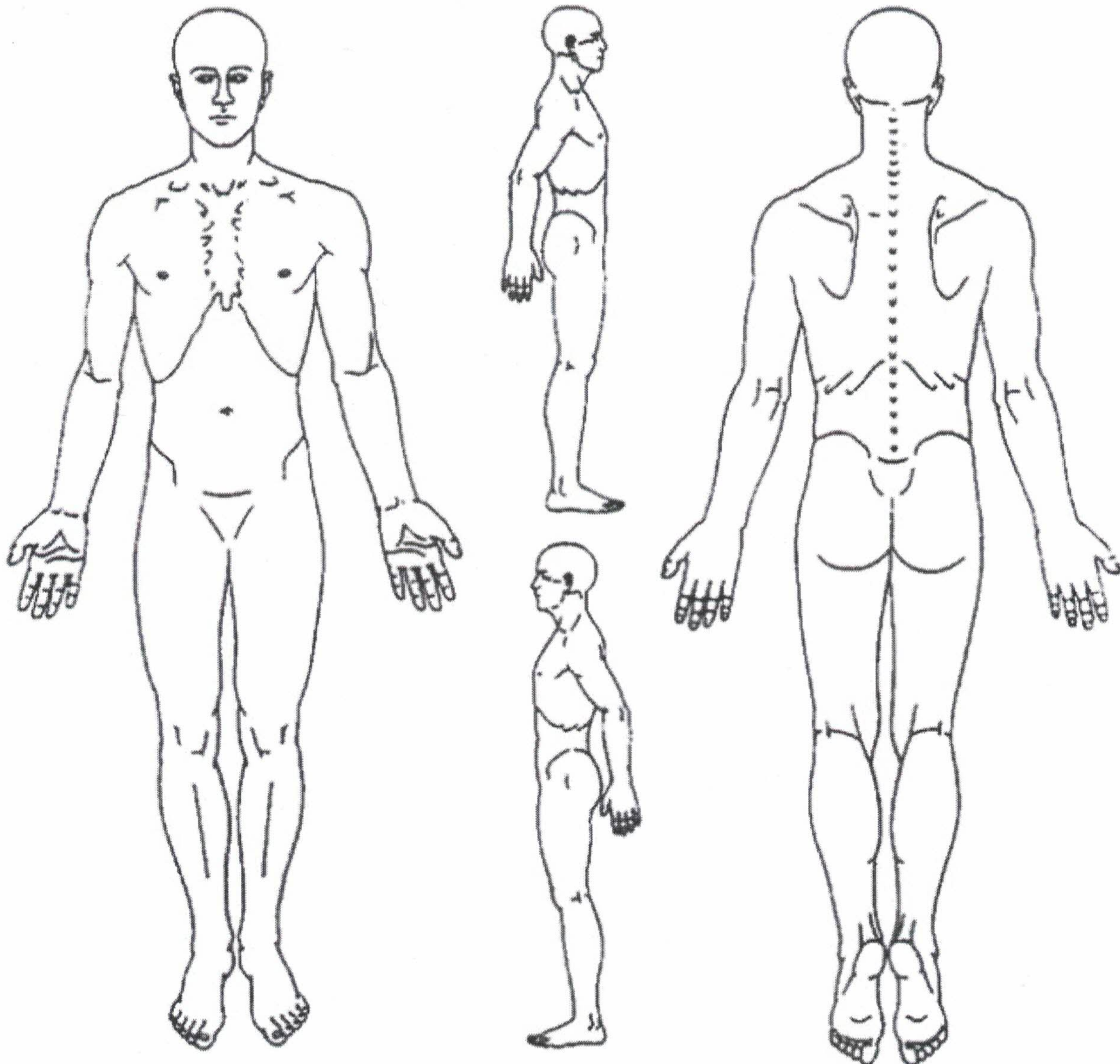
HOW LONG HAVE YOU HAD THIS PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:	A=ACHE	B=BURNING	N=NUMBNESS
	P=PINS & NEEDLES	S=STABBING	O=OTHER



OVER PLEASE

For Doctor's Use:
Chief compliant (other than neck or low back pain): ______________________________

____

(For neck conditions use the Neck Pain Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.)

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- ☐ Heart Disease
- ☐ Low Blood Pressure
- ☐ Headaches
- ☐ Blackouts
- ☐ Hernia
- ☐ Back Trouble
- ☐ Asthma
- ☐ Cancer
- ☐ Eye Trouble
- ☐ Meningitis
- ☐ Sexual Dysfunction
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Ringing In Ears
- ☐ Fainting
- ☐ Gout
- ☐ Prostate Trouble
- ☐ Allergies
- ☐ Kidney Trouble
- ☐ Hearing Trouble
- ☐ Heartburn
- ☐ Muscle Cramps
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Memory Loss
- ☐ Seizures
- ☐ Bronchitis
- ☐ Bladder Trouble
- ☐ Pneumonia
- ☐ Impotence
- ☐ Arthritis
- ☐ Pulmonary Disease
- ☐ Thyroid Trouble
- ☐ AFIB
- ☐ CHF

Height: ______ Weight: _______ Weight gain / loss in the past 2 years: ________lbs.

Blood Pressure_________

List any hospitalizations or surgeries you may have had.____

____

____

EPWORTH SLEEPINESS SCALE TEST YOUR SLEEP

0 = would NEVER doze 1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing 3 = HIGH chance of dozing

— Sitting and reading
— Watching TV
— Sitting, inactive in a public place (in a meeting or watching a movie)
— 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 the traffic

— TOTAL: A score of 8 or higher indicates you may have a sleep disorder

Have you had any previous evaluations, examinations or treatments for this sleep problem or any other sleep problem? Yes____________ No ___________

If yes briefly describe the results and treatment including medication ____________________________

____

Patient Name: ______________________ DOB: ________________ Study Date: ________________

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Bed Partner Questionnaire

(To be completed by pt's bed partner)

Patient Name: ______________________________ Date: ____________

Your Name: ______________________________ Relationship: __________

I have observed this person sleep (circle one): Never Once Twice Often Every Night

Check any of the following that you have observed this person doing while asleep. **Check** those that you consider severe problems.

__Light Snorer
__Moderate Snorer
__Loud Snorer
__Twitching or Kicking of Legs
__Choking
__Sitting up in bed Not Awake
__Head Rocking or Banging
__Biting Tongue
__Crying out
__Becoming very rigid and shaking
__Apparently sleeping even if he/she says otherwise
__Occasional Loud Snorts
__Grinding Teeth
__Pauses in Breathing
__Sleep Talking
__Bed-wetting
__Awakening with Pain
__Getting out of bed Not Awake

Other____

If this person snores, what makes it worse?
__Sleeping on his/her back
__Sleeping on his/her side
__Fatigue
__Alcohol

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

____
____
____
____
____

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes/No? If yes, please explain: ____

____
____
____
____

Does this person use sleeping pills? Yes/No? What kind? ______________________
How often?____
Does this person drink alcohol? Yes/No?
Please estimate the per (weeknight/weekend) use of: ___/___12 oz. Bottle/can/tap beer. ___/___6-8 oz. Glasses of wine ___/___ 1-1/2 oz. bottle/cap/tap liquor.
Please estimate how much alcohol this person consumes in the 3 hours before bed:

____

If this person uses recreational drugs, please describe both the types and frequency of usage:

____