SLEEP INSTITUTE of NEW ENGLAND

Accredited by the American Academy of Sleep Medicine

Medical History Questionnaire

Name:	Ht:	Wt:	Neck Size:

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): _____

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

Allergy History **Please completely fill in the circles**

Please select all that apply. During which months do symptoms occur?

O O All Months

O Spring O Summer O Fall O Winter

O January O February O March O April

O May O June O July O August

O September O October O November O December

Are your symptoms worse?

O O Morning O Afternoon O Evening O Night

O At home O At work O other location_____

Are symptoms:

O O Daily O Weekly O Monthly O Rarely

Do your symptoms interfere with your activities?

O O Not at all O A little O Moderately O All the time

Do any of the following cause or make symptoms worse?

O O Milk/Milk products O Fruit or juices O Vegetables O Eggs

O Wheat O Beer/wine O Liquors O Nuts/seeds O Fish

O Meat O Cheese O Wind O Smoke O Hay

O Soap O Damp areas O Mowing lawns O House plants O Perfumes

O Cold day O Weather change O Wet weather O Dry weather O Hot day

O Dust O Cosmetics O Paint fumes O Powder O Insecticides

O Other_____

Select all that you have in your home

O O Cat(s) O Dog(s) O Bird(s) O Other animals

O Basement O Carpet in bedroom O Woodburning stove/heat O Forced hot air heat

O Cigarette smoker O Air purifier O Allergy free pillow/mattress covers

Have you ever had a life threatening allergic reaction?

O Yes O No

Have you ever been treated with allergy shots? If yes, what were you treated for?

O Yes O No

O O Grass pollens O Molds O Weed pollens O Dust O Tree pollens O Animals

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 3-5 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 Abdominal pain O Anxiety O Attention deficit O Change in bowel habits

O Change in voice O Chronic cough O Chronic pain O Cold intolerance

O Depression O Eating disorder O Ear fullness O Excessive sweating

O Falls O Fatigue O Flushing O Heat intolerance

O High stress/tension O Hot flashes O Joint stiffness O Joint swelling

O Leg cramps O Memory problems O Muscle aches/pains O Nasal congestion

O Night sweats O Nighttime urination O Nosebleeds O Pain with breathing

O Palpitations O Runny/stuffy nose O Seizures O Shortness of breath lying down

O Sinus infections O Sexual dysfunction O Sore throat O Swelling in ankles

O Tingling/numbness O Trouble breathing through nose O Unsteady walking

O Weakness O Weight change O

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 and understand this form before seeing the doctor.

- *Co-pays are due at the time of the visit. We accept cash; check, Money Order, Visa, Mastercard and Discover.*
- *We are accepting insurance from Medicare, Aetna, Anthem, Cigna, Harvard Pilgrim, MVP, Martin's Point, Tufts and United, among others.* ***We will process your insurance claim for you.***
- *Balances after insurance determination for co-pay or deductible are due upon receipt of a Patient Statement. Patient payment plans will be considered* ***before*** *the service is provided.*
- *Physician visit no-show or cancellation within 24 hours will be subject to a* ***$75.00 cancellation fee****.*
- *Overnight sleep studies no-show or cancellation within 24 hours will be subject to a* ***$200.00 cancellation fee****.*
- *Balances over 60 days without arrangements made with the Sleep Institute Financial Office are subject to an outside collection effort.*

Insurance Policy

If you have insurance, we will assist you to receive maximum benefits but we do not guarantee any information we are given from your insurance company. It is the patient's responsibility to call and know what your benefits are and to know if you have used any of your maximum allowance or if you have a co-payment or deductible. We require your co-payments to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Pre-estimate of benefits is never a guarantee of payment by your insurance. At the time of your appointment, **please let us know of any insurance changes you may have had since your last visit.**

Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract. You are responsible to know what your deductible balance is and whether you have an additional co-pay for diagnostic procedures, which would include sleep studies.

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 which will be sent to you after insurance company determination of benefits. We will continue any proceedings needed to collect this balance.

No Insurance Policy

The Sleep Institute has a patient discount for patients without insurance. Ask your care provider for details 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.

I authorize that I have read the entire financial policy and I understand and agree with it.

_____ X_____

Print Name Date Signature

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.)

With this consent, **Sleep Institute of New England** may/may not (please circle one) call, e-mail, or mail my home or other alternative location and leave a message on voice mail or in person 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.

By signing this form, I am consenting to allow **Sleep Institute of New England** to use and disclose my protected health information to carry out treatment, payment and health care operations.

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 $25.00 fee for returned checks.

_____**initial**

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or 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**

☐ **White**

☐ **Native Hawaiian or Other Pacific Islander**

☐ **Other**

☐ **No Reply**