PASSAIC SLEEP MEDICINE AND NEUROLOGICAL SERVICES, PC

1114 CLIFTON AVENUE CLIFTON NJ 07013 SUITE 4 · 973-928-3288 · FAX 973-928-3286 ·
201 ROUTE 17 NORTH 11TH FLOOR RUTHERFORD, NJ 07070 · 201-549-8886 · 201-549-8849
WWW.PASSAICSLEEPNEURO.COM

Date:_____

Last Name: _____First Name: _____

Address_____City_____State _____ Zip_____

SS # _____ DOB: _____Employer: _____

Home Phone: _____ Cellular_____ can leave a message at home? _____

Work Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Sex: M F Marital Status: S M D W O Spouse's Name: _____

Race: Hispanic, Other

Language: English, Spanish, Other: _____

Referred by: _____

Primary Care Physician _____ Phone #: _____

Address of Primary Care Physician:
_____

Name of Pharmacy: Pharmacy _____ Phone: _____

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____ ID #: _____

Group #: _____ Insurance Company phone: _____

Name of Insured: _____ Date of Birth: _____ Relationship to patient: _____

Secondary Insurance: _____ ID # _____ Group # _____

INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize Passaic Sleep Medicine and Neurological Services to apply for benefits for services covered by them or their order. I request payment of any insurance company made directly to the attention of Passaic Sleep Medicine and Neurological Services. I authorize the release of any medical information necessary to process this request. I certify that I have reported infor regarding insurance coverage is correct.

I permit a copy of the authorization to use in place of the original. This authorization may be revoked by me or my insurance company at any time in writing.

I have been given the opportunity to read and.or receive Passaic Sleep Medicine and Neurological Services Privacy Notice Practices.

Signature: _____ Date:_____

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What is the purpose of your visit?

_____

Personal history: Circle condition you have or have had

STROKE / TIA
MIGRAINE
SEIZURE
PARKINSON
COPD
BLOOD CLOT
ARTHRITIS
CANCER
HYPERTENSION
DIABETES
HIGH CHOLESTEROL
HEART DISEASE

Memory Problems
HEAD inury
psychiatric admissions
Thyroid problems
REFLUX
Liver or kidney disease
Pulmonary disease / asthma
heart attack
SPONTANEOUS MISCARRIAGE
Difficulty sleeping
SEIZURE

Other_____

SURGICAL HISTORY: PLEASE SURGERIES list and dates

_____
_____

Previous tests (MRI CT evidence of sleep EEG EMG)

_____

FAMILY HISTORY: CIRCLE CONDITIONS

Headaches / Migraines
STROKE / TIA
ARTHRITIS
HEART DISEASE
HYPERTENSION

CANCER
SEIZURE / EPILEPSY
DIABETES
HIGH CHOLESTEROL

SOCIAL HISTORY

Alcohol Y N Socially IF Yes how many drinks / day? _____ type_____

Tobacco Y N If current smoker: how many packs/day _____

If you quit, how long ago _____

Drug/food allergies: _____

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Sleep Questionnaire

Patient Name_____

1.Has your weight?
a. increased
b. Decrease
c. No change

2. You Snore:
a. yes
b. no
c. Do not know

3. Loudness Snoring
a. Strong as breathing
b. Strong as talk
c. Stronger than talk
d. Very high

4. Snoring frequency
a. Almost every day
b. 3-4 times per week
c. 1-2 times per week
d. 1-2 times per month
e. Never or almost never

5. His snoring bother other people?
a. yes
b. No

6. How often have your breathing pauses been reporting?
a. Almost every day
b. 3-4 times per week
c. 1-2 week
d. 1-2 months
e. Never or almost never

7. Tired after sleeping?
a. Almost every day
b. 3-4 times per week
c. 1-2 times per week
d. 1-2 times per month
e. Never or almost never

8. Tired during wake time?
a. Almost every day
b. 3-4 times per week
c. 1-2 times per week
d. 1-2 times per month
e. Never or almost never

9. Have you ever fallen asleep while driving?
a. yes
b. no

10. Have high blood pressure?
a. yes
b. no
c. Do not know

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Review of Systems: Please let us know if you have any of the following symptoms

Name_____Date of Birth: _____

Constitutional: none> Fever> chills> weight gain> Weight loss> Fatigue> changes in appetite

HEENT:> no> Sinusitis> congestion> Blurred vision> dry eyes> Eye pain
> Hearing Loss> bell / fullness in the ears> mouth sores> sore throat> hoarseness
> Problems swallowing> mass> bleeding

Cardiovascular:> none> chest pain / pressure> palpitations> fast or irregular heartbeat> swelling in the arms / legs> poor circulation

Respiratory:> none lack> of breath with and without exertion> unusual / persistent cough

GI:> none> nausea> vomiting> diarrhea> Abdominal pain> changes in bowel habits tarry stool> Dark> Loss of bowel control

GU:> none> loss of bladder control> emergency> increased frequency> trouble starting> painful urination> blood in urine

Musculoskeletal:> no> Joint Pain> Muscle Pain> immobility or loss of function> head / neck / back pain> pain when walking

Integumentary:> none> mass> rash> skin lesions> levido reticularis

Psychiatric:> none> Anxiety> Depression> mood swings> psychiatric hospitalizations
> Sleep Disorders

Endocrine:> none> unusual weight loss / gain> excessive urination> excessive thirst
Tolerance> Hair Loss / gain> hot / cold> nipple discharge> loss of sexual desire or ability
> Installation> change difficulty menstrual period / irregularity

Heme / Lymph:> none> unusual bleeding> easy bruising lumps> clotting or skin

Neurological:> None> headache> nausea / vomiting> stun> Seizures> blackouts
> Approved by fainting (syncope)> trauma> lights> increased sleepiness
> Difficulty sleeping> wake snoring> night

Mental state> none> confusion> alteration / loss of consciousness
> Difficulty expressing / understanding speech confusion >> memory problems> personality changes

CNS:> no> Vision Loss> blurred / double vision> numbness / weakness in the face> face fallen> taste / smell loss or changes> hearing loss / ringing> vertigo / dizziness> difficulty swallowing
> Difficulty speaking

Motor:> none> trembling> spasms atrophy >> Weakness> cramps (pre / post exercise)

Coordination:> none> instability difficulties balancing> problems> awkwardly reach objects

Sensory:> none> numbness> heavy> Pain> tingling> falls with eyes closed or when taking a shower

Movement:> none> difficulty walking> falling aside> feeling of being pushed down

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DRUG REVIEW
(Please include vitamins, prescription medicines and supplements)

Patient Name_____ DOB _____

Pharmacy_____ City _____

Phone_____

Drug	dosage	frequency	prescribing dr

Passaic Sleep Medicine and Neurological Services, P.C.

Financial Liability Acknowledgment Form

1. **PAYMENT** is expected at the time of your visit. We will accept cash or check. If payment is returned by bank, there will be a $30 charge, which will be due immediately in the form of cash only. Payment will include any unmet deductible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. We do ask for a copy of insurance card and ID or license. If you cannot for some reason make your appointment, please call the office to reschedule. Failure to do so will result in a $50 No Show fee for a consultation or follow up visit, which will be due immediately. If your appointment was for a test the No Show fee will be as follows: EEG $100, VNG $100, EMG $200.

2. **INSURANCE** we are participating providers with several insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If your plan requires a referral, it is your responsibility to make sure the referral is on file. If the referral is not on file, payment in full is due at time of service. If referral is received we will file claim to insurance and make any necessary refunds after payment is received from your insurance.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. This means the insurer may send the payment directly to you and therefore, our charges for your care are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You are responsible for payment if your claim rejects for lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **ACCOUNTING PRINCIPLES** Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.

4. **COMPLETING INSURANCE FORMS, COPYING MEDICAL RECORDS, ETC** requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, or for extra transcription by the doctors. The charge is determined by the length and complexity of the form or letter.

5. Appointments are scheduled every 15 minutes. In order to keep on schedule and respect the time of the patients and doctor, if you arrive more than 15 minutes late for your appointment, you may need to reschedule depending on the schedule of the office. We ask that if you know you will be late to please call the office to inform us and we can let you know whether you will need to reschedule.

If you have questions in regard to any of your billing statements, our staff is available to assist you.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or Responsible Party, if minor) Date

____
Please Print Your Name