ELITE SLEEP

New Patient Sleep Questionnaire

Date: _____

Name: _____ **Age:** _____ **Ht:** _____ **Wt:** _____

1. What time do you typically go to bed? _____

2. Do you have difficulty *falling* asleep at the beginning of the night? Yes or No
   If yes, on average how long does it take to fall asleep? _____

3. Do you plan your next day's activities while lying in bed trying to fall asleep? Yes or No

4. Do you have racing thoughts going through your mind while trying to fall asleep or after waking up in the middle of the night? Yes or No

5. Do you have difficulty *staying* asleep throughout the night? Yes or No
   If yes, how many times do you wake up during the night? _____

6. How long does it take you to fall back to sleep? _____

7. When do you typically wake up to start your day? _____ Do you need an alarm clock? Yes or No

8. Do you feel refreshed when you awaken to start your day? Yes or No

9. Do you experience an unsettled, *restless* sensation in your legs while lying in bed? Yes or No
   If yes, how often: Rarely (25%)____Half the time (50%)____Most of the time (75% or more)

10. Have you been told that you make kicking and *twitching* movements while asleep? Yes or No

11. Do you *snore* at night? Yes or No
    If yes, how would you rate the severity? Mild Moderate Severe

12. Have others told you that you have *pauses* in breathing or frequent gasping sounds sleeping? Yes or No

13. Does your bed partner frequently sleep in another room because of how you sleep? Yes or No

14. Check those that apply to you:
    Do you frequently wake up with:
    __a dry mouth __headaches __excessive sweating
    __aching jaws (or grind or clench your teeth in your sleep) __choking or gasping
    __nasal congestion on awakening (which was not present when you went to bed)
    __chest pain __heart burn __drooling on the pillow

15. Are you *sleepy* during the day? Yes or No

16. Do you take naps often? Yes or No
    If yes, for how long? _____

17. How many caffeinated beverages do you consume each day? _____

18. Do you occasionally awaken feeling *paralyzed*? Yes or No

19. Do you experience *sudden loss* of strength in your legs or arms during the day? Yes or No
If yes, are these brought on by a sudden frightening event or laughter? Yes or No

EPWORTH SLEEPINESS SCALE (Please fill out for insurance purposes):

Rank how likely it would be for you to become drowsy (like you're going to fall asleep) during the day in the following situations (in contrast to feeling just tired):

0 = Never become drowsy 1 = Rarely become drowsy 2 = Frequently become drowsy 3 = Always become drowsy

Chance of Becoming Drowsy Situations:

0	1	2	3	Sitting and reading
0	1	2	3	Watching TV
0	1	2	3	Sitting, inactive in a public place (e.g. theater)
0	1	2	3	As a passenger in a car for an hour without a break
0	1	2	3	Lying down to rest in the afternoon when circumstances permit
0	1	2	3	Sitting and talking to someone
0	1	2	3	Sitting quietly after lunch without alcohol
0	1	2	3	In a car, while stopped for a few minutes in the traffic

TOTAL FROM ABOVE: _____

My sleep problems are:

My other medical problems are:

ELITE SLEEP

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Are you on a special diet? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, please explain: _____

Do you use controlled substances? Yes No If yes, please explain: _____

Women: Are you

Pregnant/Trying to get pregnant Yes No Taking oral contraceptives Yes No Nursing Yes No

Are you allergic to any of the following

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following? (Please circle any that apply)

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina Arthritis/Gout
Anxiety
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Congenital Heart Disease
Convulsions
Depression
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough Frequent
Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur Heart
Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Insomnia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Sleep Apnea
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Elite Sleep providers of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

ELITE SLEEP

Personal Medication List

Your Name: _____ Date: _____

Primary Care Doctor: _____ Doctor's Phone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Allergies to Medications: _____

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions
Over-the-Counter Medications	**Purpose or Reason Taken**	**Dose**	**Time(s) of Day**	**Form (Liquid, capsule, tablet)**	**Special Instructions**

ELITE SLEEP

HIPPA Release for Insurance And Financial Responsibility

As a courtesy, our office will file claims and deal with insurance matters for you. However, your insurance policy is a contract between you and your insurance company, we are not a party to that contract. Consequently, we require you to give us permission to release your information in order to process your insurance claim. Any balance owed after insurance pays is your responsibility.

I,_____, authorize payment of medical benefits to Elite Sleep, LLC for services rendered. I also authorize the release of any information necessary to process my insurance claims to Elite Sleep, LLC. I understand that I am fully responsible for any amount not covered by my insurance, and acknowledge full responsibility for payment when insurance benefits are terminated prior to testing. All deductibles, co-insurance payment, and co-pays are to be paid *in full* prior to time of service unless prior arrangements are made. Payment arrangements are available for balances over $500.00.

By signing this document, I agree that I have read, understand, and agree to the terms of this document.

_____ _____

Name (Please print) **Date**

_____

Signature

ELITE SLEEP

Effective date of notice: January 1, 2021

Elite Sleep, LLC
9633 Market Place, Suite 201
Lake Stevens, WA 98258
Phone (425) 377-9988 • Fax (425) 880-5815

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for a specific purpose;

For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

Uses or disclosures for health related research;

Uses and disclosures to prevent a serious threat to health or safety;

Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the Foreign Service;

Disclosures of de-identified information;

Disclosures relating to worker's compensation programs;

Disclosures of a "limited data set" for research, public health, or health care operations;

Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-Mail shown at the beginning of this Notice.

Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, please contact the office contact person at the address or phone number shown at the beginning of this Notice.

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Elite Sleep, LLC Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____