Overlake Internal Medicine Associates
OVERLAKE SLEEP DISORDERS CENTER
1100 112th Avenue NE, Suite 320 Bellevue, WA 98004
Phone (425) 289-3000 Fax (425) 289-3240

Date ____________________

Dear ____,

Thank you for choosing Overlake Sleep Disorders Center for your care. We look forward to seeing you on _________________________, at ______________a.m/p.m. Please complete the attached documents and bring them with you to your appointment. Directions to the Overlake Sleep Disorders Center are also attached.

Thank you,

Overlake Sleep Disorders Center

Scott Bonvallet, M.D., FCCP **Randip Singh, M.D.**

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24-HOUR CANCELLATION POLICY

Due to the nature of overnight sleep studies, it is necessary to make individual reservations for sleep studies. The following policy assures our ability to maintain availability of therapy, appropriate staffing, and timely service.

- For daytime appointments, please arrive fifteen minutes early to register and fill out paperwork.

- If you are more than 10 minutes late for any appointment, you may be asked to reschedule your appointment.

- If you must cancel or change your appointment for any reason, please do so at least **24-hours** in advance of your scheduled arrival time.

- For overnight appointments, there will be a non-refundable **two hundred-fifty dollar ($250.00)** charge if you miss your appointment without a **24-hour** notice. Please understand this charge is not covered by insurance.

- As a courtesy, we will attempt to confirm your appointment by telephone two to three days prior to your appointment. If we are unable to do so, please feel free to call to confirm your appointment at (425) 289-3000.

All cancellations and issues associated with appointments should be directed to the Overlake Sleep Disorders Center, (425) 289-3000. Business hours are Monday – Friday, 7:30 a.m.- 5:00 p.m.

Thank you for your cooperation,

Overlake Sleep Disorders Center

Scott Bonvallet, M.D., FCCP **Randip Singh, M.D.**

Overlake Sleep Disorders Center

Account #:______________________________

Legal Name: ____
(First) (Middle) (Last)

Date of Birth:__________________________ Sex: Male____ Female_____ Social Security #: ________________________________

Address:____
(Street) (Apt./Unit#) (City) (State) (Zip)

Home #: ______________________________ Work #:______________________________ Cell #:___________________________________

Neck Size:_______________________ Are you a shift worker? Yes_____ No_____ Shift Hours: _______________________

Allergies: ____

Marital Status: __________________ Name of Spouse: ________________________ Spouse's Contact Phone #: ____________________________

Employer : ____

Address: ____
(Street) (Suite) (City) (State) (Zip)

Occupation: ____ Years @ your job: _________ If retired, as of what date? __________

Emergency Contact Name: ____ Relationship: ______________________________

Contact Phone #: __________________________________

Physician Information

Referral Source: Physician / Family / Friend / Other ____

Referring Physician: ____/ Phone#:______________________________

Regular / Primary Physician: ____/ Phone #: _____________________________

Insurance Information

Primary Insurance: ____

Policy Holder's Name: ____ Birth date: _________________

ID #: ____ Group #: _______________________________________

Your relation to Policy Holder:____________________________________ Co-pay: ____________

Secondary Insurance: ____

Policy Holder's Name: ____ Birth date: ________________

ID #: ____ Group #: _______________________________________

Your relation to Policy Holder:_____________________________________ Co-pay: ____________

The above information is true to the best on my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made with this office, in advance. I authorize the physicians and Overlake Internal Medical Associates to release any information required to process my insurance claims. I also authorize payment of insurance benefits directly to Overlake Internal Medicine Associates.

Signature:____ **Date:** ____________________________

PATIENT NAME	DATE OF BIRTH	ACCOUNT NUMBER

CONSENT TO CARE AND FINANCIAL RESPONSIBILITY

MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, the Sleep Center and its employees, and all other persons caring for me to provide treatment and care as may be deemed necessary and available to me during my stay in the Sleep Center including, but not limited to tests, examinations and medical treatment. I understand that my care is under the control of my attending physicians who are independent practitioners. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination at the Overlake Sleep Disorders Center.

PHOTOGRAPHS: The taking, reproduction and use of photographs will be done in connection with my diagnosis, care and treatment at Overlake Sleep Disorders Center. Photographs include the use of video and television monitoring by the technical staff and physicians.

OBSERVATIONS: For the purpose of advancing medical knowledge and training, I consent to the presence of observers during tests, examinations and other procedures.

RELEASE OF INFORMATION: I hereby authorize Overlake Sleep Disorders Center to disclose all or any part of my record, and any other information in the Center's possession, to any other person or entity which is or may be liable for all or part of the charges related to my care, including, but not limited to worker's compensation carriers, insurance companies, welfare funds, or my employer. I hereby release Overlake Sleep Disorders Center from all legal responsibility or liability, which may arise from disclosure of my record as provided in this paragraph. I hereby authorize Overlake Sleep Disorders Center to furnish requested information excerpts from my record to any insurer, its intermediary or another health care facility to provide continuity of care. Overlake Sleep Disorders Center may periodically participate in statistical research studies. I agree that statistical information can be released on an anonymous/confidential basis. I understand that Overlake Sleep Disorders Center keeps a record of the health care services provided and that I may request to review my record (a 24-hr notification is required). I may request a copy of all or any part of my record, (there is a charge for this service), and I may ask Overlake Sleep Disorders Center to correct that record. Except as noted above, Overlake Sleep Disorders Center will not disclose my record unless I direct them to do so, unless the law authorizes or compels them. I may see my records or get more information about it from the medical records department at Overlake Sleep Disorders Center.

I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION AND THAT I UNDERSTAND ITS CONTENT, MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM.

Signature of patient (if not a minor)____Date___________________Time______________

The patient is unable to consent because____

Signature of parent/guardian/other______________________________________Relationship_________________Date_____________Time________

FINANCIAL AGREEMENT/PATIENT RESPONSIBILITIES:

You have the RESPONSIBILITY to:

- Provide accurate and complete details about your illness, hospitalization, medications and present conditions.
- Tell your doctor about any change in your condition or if problems arise.
- Tell your doctor or nurse if you do not understand your treatment or what you are expected to do.
- Accept financial responsibility for payment of services, pay your bill promptly or to inform OIMA Billing office if you are unable to pay your bill.
- Notify Overlake Sleep Disorders Center of any changes in healthcare benefits.

Initials _________ of Patient (if not a minor)

Initials _________ of Patient/Guardian or Other _________________ Relationship______________________ Witness________________________

I UNDERSTAND THAT I CAN REQUEST A COPY OF OVERLAKE SLEEP DISORDERS CENTER'S NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES INFORMATION ABOUT HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED.

Initials_______________________ of Patient/Guardian * Initials imply full signature

Overlake Sleep Disorders Center	1100 – 112th Avenue NE, Suite 320 Bellevue, WA 98004 (425)289-3000 Fax (425) 289-3240 Scott T. Bonvallet, M.D., FCCP Randip Singh, M.D.

Name: ____ MR#: __________________________

Primary Care Physician: ___________________________ Referring Physician: _____________

1. What are your primary concerns about your sleep? ____
2. Have you ever had a sleep study? _____ If yes (please bring a copy of the report with you), when and where was the study done and what were the results? _____________________________________
   ____
3. Any recent CT scans of your head or sinus? MRI of brain? Chest X-ray or relevant scan? _________
4. Any recent Echocardiogram or EKG? ____
5. Any recent lab work (electrolytes, thyroid, CBC, B_{12}, Iron)? _____________________________
6. Please list any hospitalizations and/or surgeries that you have had. List the most *current* first.
   ____
   ____
7. Have you ever seen an ear nose & throat specialist, pulmonologist, neurologist, psychiatrist or allergist?
   ____
   ____
8. Please list any **medication allergies** you have:
   ____
   ____

HEALTH HISTORY

Please check any problems or illnesses that you have had:

- ❑ Alcohol/Drug abuse
- ❑ Anemia or iron deficiency
- ❑ Anxiety
- ❑ Asthma
- ❑ Atrial fibrillation/Flutter
- ❑ Back Trouble
- ❑ Bladder Trouble
- ❑ Bronchitis
- ❑ Cancer (What type?)_________
- ❑ Cholesterol
- ❑ Depression/Bipolar
- ❑ Diabetes
- ❑ Dizziness
- ❑ Fibromyalgia or pain syndrome
- ❑ Headache
- ❑ Heart Disease
- ❑ Heartburn
- ❑ High Blood Pressure
- ❑ Impotence/Libido
- ❑ Kidney Trouble
- ❑ Loss of Consciousness
- ❑ Muscle Cramps
- ❑ Obesity
- ❑ Parkinson's Disease
- ❑ Pneumonia
- ❑ Prostate Trouble
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ TMJ
- ❑ Tonsillectomy
- ❑ Tuberculosis

9. Please list any medications you are currently taking including prescriptions and over the counter:

Medication	Dose/Frequency	Medication	Dose/Frequency
1.		**8.**	
2.		**9.**	
3.		**10.**	
4.		**11.**	
5.		**12.**	
6.		**13.**	
7.		**14.**	

DIET & EXERCISE	✓ YES
How many beverages containing caffeine or Taurine (i.e. Red Bull) average per day?	
Do you exercise or have you had a recent change in exercise habits?	
Any changes in your diet recently?	
Any weight fluctuations? If so, increase or decrease?	
NASAL / SINUS	**✓ YES**
Tonsillectomy or Adenoidectomy?	
Chronic Sinusitis or postnasal drip?	
Nasal polyps or congestion?	
History of nasal fracture?	
Use of intranasal steroidal sprays?	
Seasonal allergies (trees, grass, mold, dust, animal dander)?	
Use of decongestants or antihistamines?	
Surgical interventions for sleep problems/nasal problems or sinus problems? (i.e., UPPP, resection of turbinates, septoplasty)?	
Do you sleep with your mouth open?	
DAYTIME FUNCTIONING	**✓ YES**
Is your motivation level low?	
Are you easily distracted?	
Do you lose focus when listening or have difficulty concentrating when you read?	
Do you need instructions repeated or have difficulty tracking two things at once?	
Do you have difficulty finding words while talking or difficulty with mental arithmetic?	
Are you depressed?	
Are you irritable or would your significant other say that you are irritable?	
Are you impulsive or impatient?	
Do you have difficulty with your short-term memory?	

ENVIRONMENT

Please check any of the following that are in your sleeping environment:

- ❑ Appliances (i.e., Washer/Dryer or Dishwasher)
- ❑ Bed partner
- ❑ Children
- ❑ Computer
- ❑ Light
- ❑ Noise
- ❑ Pets
- ❑ Television
- ❑ Other ______________________ ______________________ ______________________

SLEEP HABITS	✓ YES
Have you ever taken any prescription or over the counter medication to help you sleep? If so, what have you taken?	
Is 8 hours of sleep necessary?	
Do you take naps?	
Do you read, watch television or use the computer before bed?	
Do you eat or snack prior to going to bed?	
Do you have racing thoughts while you are in bed?	
Have any of your medications changed the quality of your sleep?	
Do you currently or have you ever worked nights?	
SLEEP SCHEDULE	
How long does it take you to fall asleep?	
What is your bedtime?	
How often do you wake up in the middle of the night?	
If you wake up from sleep, how long does it take you to fall back asleep usually?	
What time do you wake up in the morning?	
Do you take naps? If so, for how long?	
Do you sleep in on the weekend?	

BED PARTNER QUESTIONNAIRE

Name of Patient: ____________________________________ Date: ____________________________

Name of person completing this section: ____

I have observed this person's sleep: ☐ Never ☐ Once or twice ☐ Often ☐ Every night

Check any of the following behaviors that you have observed this person doing **while sleeping**:

- ❑ Light snoring
- ❑ Loud snoring
- ❑ Head rocking or banging
- ❑ Choking
- ❑ Pauses in breathing
- ❑ Occasional loud snorts
- ❑ Getting out of bed but not awake
- ❑ Twitching of arms during sleep
- ❑ Twitching or kicking of legs during sleep
- ❑ Crying out
- ❑ Sitting up in bed not awake
- ❑ Biting tongue
- ❑ Sleepwalking
- ❑ Grinding teeth
- ❑ Other ____________________

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No

If so, please explain ____

Additional comments ____

SLEEP RELATED PHENOMENA	✓ YES
Headache? If yes, have you experienced any: ☐ numbness ☐ tingling ☐ changes in vision ☐ rapid heartbeat ☐ tearing or light sensitivity	
Witnessed apnea or pauses in breathing?	
Night sweats?	
Snoring? If yes, any changes in intensity or duration?	
Nodding off behind the wheel of a motor vehicle?	
Have you experienced choking, gasping arousals or snorting?	
Do you grind your teeth? If yes, do you wear a mouth guard?	
Do you have heartburn during the day or at night?	
While awake, have you had any shortness of breath when lying on your back?	
Have you ever been on a ventilator?	
Any swelling in your legs?	
Is your sleep worse before your menstrual cycle?	
Cyanosis in the morning (skin is blue)?	
Have you ever had the carbon monoxide levels checked in your home?	
Sleep walking, talking, eating; night terrors or waking up screaming?	
Do you act out your dreams (e.g. punching or kicking)?	
Coarse breathing or wheezing at night?	
Do you frequently wake up to urinate at night?	
Do your legs cramp at night?	
Do you feel discomfort in your legs? If yes: ☐ Is it more noticeable at night? ☐ Does it improve with movement?	
Have you ever felt weak during a bout of laughter?	
Have you ever woken up in the middle of a dream unable to move?	
Do you dream during naps?	

How likely are you to doze off or fall asleep in the following situations?
SCALE: 0 = would never doze 1 = slight chance 2 = moderate chance 3 = high chance

SITUATIONS	SCALE			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car	0	1	2	3
Lying down to rest in the afternoon	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 in traffic	0	1	2	3

What is your **Family Medical History**?:

Father:____

Mother:____

Social History:

Occupation:____

How many alcoholic beverages do you average in a week?_______________________________

Do you use tobacco, if so, how often?____

Do you use any illicit drugs and if so which one(s)?