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Diplomat in Sleep Medicine

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75. N. Country Road • Port Jefferson, NY 11777
Phone 631-476-2721 • Fax 631-476-2772

Patient's Name: _____

Appointment Date: _____Time: _____

This is confirmation of your appointment with Dr. _____

Enclosed you will find a packet of papers. On the day of your appointment, **please bring all of the following:**

- The completed packet of paperwork
- Insurance Card(s)
- License or Photo ID
- Any referrals (if required by your insurance company)

Please call within 48 hours if you cannot make this appointment.

There is a $25.00 charge for any and all missed appointments.

Directions to the Office:

Sleep Disorders Center
Mather Hospital
Frey Family Foundation Medical Arts Building
625 Belle Terre Road
Port Jefferson, NY 11777
1st Floor

PLEASE NOTE

Due to the variety of insurance plans that are now available to patients (especially PPO, POS, etc), you are advised to call your insurance company and confirm your potential financial responsibility

If you have a sleep study done, it may be required that you stay over for 1 or 2 nights. This is an outpatient procedure and there might be a co-insurance or co-payment due.

Mather Hospital
Northwell Health
Sleep Disorders Center

Patient's Legal Name: _____ _____ _____
Last First MI

DOB: _____ Gender: Male Female Social Security #: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact Preference: _____

Marital Status (circle one): Single Married Divorce Separated Widowed Living Together

Race (circle one): American Indian or Alaska Native Black/African American Chinese Filipino Guamanian or Chamorro Hispanic White Japanese Korean Native Hawaiian Other Asian Other Pacific Islander Other Race Samoan Vietnamese White/Caucasian Undisclosed

Ethnicity (circle one): Cuban Mexican/Mexican American Not Hispanic or Latino Other Hispanic or Latino Puerto Rican

Health Care Proxy? Yes No Name: _____ Phone #: _____

Primary Language: _____

Primary Care Physician: _____

EMERGENCY CONTACT:

Name:_____ Relationship_____

Address: _____ City: _____ Zip Code :_____

Phone Number: (H)_____(C)_____

PRIMARY INSURANCE:

Insurance Plan:_____ Policy Number:_____

Policy Holder: _____ Relation to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

SECONDARY INSURANCE:

Insurance Plan:_____ Policy Number:_____

Policy Holder: _____ Relation to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

Mather Hospital Northwell Health® • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

SD5380

Patient Name:_____
Male_____ Female_____ Age Date of Birth:_____
Height _____ Weight _____ Neck Size _____ inches

Primary Care Physician:_____ Referring Physician:_____

1. Please describe your sleep problems in your own words. Please be as detailed as possible.
   a. _____
   b. _____
   c. _____
   d. _____

2. How long have you had your sleep problem?_____
3. Have you or your partner noted loud snoring or abnormal breathing during sleep?
   _____ Yes _____ No
4. Do you have frequent difficulty concentrating or have lapses in attention due to drowsiness?
   _____ Yes _____ No
5. Do you take naps during the day? _____ Yes _____ No
   i. If yes, how long? _____
   ii. Do you awaken refreshed? _____ Yes _____ No
6. What time do you get into bed?_____
7. How long does it take you to fall asleep after lights out?_____
8. Do you awaken during the night? _____ Yes _____ No
   i. If yes, how many times? _____
   ii. Do you get out of bed? _____ Yes _____ No
   iii. Do you stay in bed trying to get back to sleep? _____ Yes _____ No
   iv. How long does it take for you to fall back asleep?_____
   v. What do you do in the meantime?_____
9. What time do you arise in the morning?
   i. Weekdays (Work days) _____ Weekends (Days off) _____
   ii. Do you feel more refreshed when you sleep in? _____ Yes _____ No
10. Do you awaken refreshed?_____ Yes _____ No
    i. Tired and groggy? _____ Yes _____ No
    ii. With headaches? _____ Yes _____ No
11. Were you a good sleeper prior to your sleep problem?_____ Yes _____ No
12. Were you ever unable to more your arms and legs upon awakening?
    _____ Yes _____ No

13. Do you become weak in the knees with laughter or strong emotion?
    _____ Yes _____ No
14. Do you feel sleepy while driving?
    Always _____ Sometimes _____ Rarely _____ Never_____
15. Have you ever walked in your sleep? _____ Yes _____ No
16. Are you a restless sleeper, thrash, or kick? _____ Yes _____ No
17. Have you gained or lost significant weight over the last year?_____ Yes _____ No
18. Do you get tingling, weakness, cramps, twitches, or other "funny" feelings in your legs that make you keep moving or flexing them and prevent you from sleeping or relaxing?
    _____ Yes _____ No
19. Were you ever knocked unconscious, or suffered a major head injury?
    _____ Yes _____ No
20. Have you ever had a major infection of the central nervous system (meningitis, encephalitis, etc)?
____ _____ Yes _____ No
21. Please list all the medications dose and frequency you are currently taking, or took in the last 3 months:

    _____

    _____

    _____

22. Does anyone in your family snore or have been told they have Sleep Apnea?
    If yes, relationship _____
23. Have you ever bee told that you have: ***Circle all that apply:***

High Blood Pressure	Diabetes	Allergic Sinusitis	Deviated Nasal Septum
Asthma COPD	Neuropathy	Thyroid Condition	Seizures or Epilepsy
Heart Condition	Depression	Acid Reflux (GERD)	Psychiatric Disturbances

    Other:

    _____

24. Please list all allergies (pollen/dust), drug allergies, or any other medical facts that you may feel are important?

    _____

    _____

    _____

25. Have your tonsils ever been removed?_____
26. Is your nose constantly running or frequently congested?_____
27. Present occupations and working hours:_____
28. **My major problem(s)** ***Check all that apply:***

_____ Sever daytime drowsiness
_____ Difficulty falling or staying asleep
_____ Problems breathing at night or snoring
_____ Doing unusual things in my sleep (i.e. sleep walking, night terrors, night sweats, bed wetting, screaming, etc.)
_____ Other (please explain)

29. Please rate your likelihood to fall asleep under the following conditions?
    (0 = Never, 1 = Slight, 2 = Moderate, 3 = Severe)
    i. Sitting and reading _____
    ii. Watching TV _____
    iii. Sitting inactive in a public place _____
    iv. As a passenger in a car for at least an hour without a break _____
    v. Lying down in the afternoon, when circumstances permit _____
    vi. Sitting and talking to someone _____
    vii. Sitting quietly after lunch without alcohol _____
    i. In a car, while stopped for a few minutes in traffic _____
30. Are you presently under unusual stress at home? _____ Yes _____ No
    At work? _____ Yes _____ No
31. What medications do you take to help you fall asleep?

    _____

    _____
32. Do you ever have a dream like (visual) experiences after wakening?
    _____ Yes _____ No
33. Do you remember your dreams?
    i. Usually _____ Rarely _____ Never_____
    ii. Are they usually: Non-frightening _____ Frightening_____
34. Are they vivid? _____ Yes _____ No
    Only small fragments? _____ Yes _____ No
35. How many cups of caffeineated beverages do you consume daily?_____
36. How much alcohol do you consume daily? (please be specific)

    _____
37. How much do you smoke? _____
38. Do you need assistance to be mobile?_____ Yes _____ No
39. Do you need assistance to the bathroom? _____ Yes _____ No
40. Do you have any special needs that we should be aware of?
    a. _____
    b. _____
    c. _____
    d. _____

Person completing interview _____

Date: _____ Time: _____

Important Information about Paying for Your Care at Mather Hospital

John T. Mather Memorial Hospital is a participating provider in many health plan networks. You can find a list of the plans in which we participate at **www.matherhospital.org/yourcare.** Some health plans use smaller networks for certain products they offer so it is important to check whether we participate in the specific plan you are covered by. Our list will tell you if we do not participate in all of a health plan's products.

It is also important for you to know that the physician services you receive in the hospital are not included in the hospital's charges. Physicians who provide services at the hospital may be independent voluntary physicians or they may be employed by the hospital. Physicians bill for their services separately and may or may not participate in the same health plans as the hospital. You should check with the physician arranging your hospital services to determine which plans that physician participates in. Plan participation information for physicians employed by the hospital can be found at **www.matherhospital.org/yourcare.** Mather Hospital contracts with a number of physician groups, such as anesthesiologists, radiologists and pathologists, to provide services at the hospital. Contact information for the physician groups the hospital has contracted with is available at **www.matherhospital.org/yourcare.** You should contact these groups directly to find out which health plans they participate in.

You should also check with the physician arranging for your hospital services to determine whether the services of any other physicians will be required for your care. Your physician can provide you with the name, practice name, mailing address and telephone number of any physicians whose services may be needed. Your physician will also be able to tell you whether the services of any physicians employed or contracted by Mather Hospital are likely to be needed, such as anesthesiologists, radiologists and pathologists. Contact information for these physicians is available at **www.matherhospital.org/yourcare.** You should contact these groups directly to find out which health plans they participate in.

Hospitals are required by law to make available information about their standard charges for the items and services they provide. This information is available by contacting our Insurance Verification Department at 631-686-7907 between 8am-4pm, Monday-Friday. You will be given a written estimate of charges within three business days of your request.

If you do not have health insurance, you may be eligible for assistance in paying your hospital bills. Information about financial assistance is available at **www.matherhospital.org/charitycare** or by calling our Charity Care Office at 631-473-1320, ext. 4037 between 8am-4pm, Monday-Friday.