EL PASO SLEEP CENTER

West
4305 N. Mesa Suite B
El Paso, TX 79912

East
3030 Joe Battle
El Paso, TX 79938

PRE-REGISTRATION INFORMATION

Appt. Time & Date: ______________________ *Dr.* ______________________

Last Name: ____________________ *First Name:* __________________ *MI* _____ *Gender: M / F*

Date of Birth: ___/____/____ *Social Security Number:* ______________________

Guarantor Name (if different from patient): ______________________________

Address: ______________________ *City:* ______________ *State:* _____ *ZIP:* ________

Home #: (___)______________ *Work #:* (___)______________ *Cell #:* (___)______________

Referring Physician: ______________________ *PCP:* ______________________

Emergency Contact: ____________________ *Relationship:* __________ *Phone #:* (___)________

How did you hear about EL PASO SLEEP CENTER? ______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________________ *Phone #:* (____)______________

Insurance Address: ____________________ *City:* __________ *State:* __________ *ZIP:* _____

Subscriber Name: __________________________ *SSN:* __________________ *DOB:* ________

ID Number: ______________________________ *Group #:* ______________________

Patient to subscriber relationship: *Self* *Spouse* *Parent* *Child* *Other:* ____________________

Subscriber Employer: ______________________ *Employer #:* ______________________

SECONDARY INSURANCE: ______________________________ *Phone #:* (____)______________

Insurance Address: ____________________ *City:* __________ *State:* __________ *ZIP:* _____

Subscriber Name: __________________________ *SSN:* __________________ *DOB:* ________

ID Number: ______________________________ *Group #:* ______________________

Patient to subscriber relationship: *Self* *Spouse* *Parent* *Child* *Other:* ____________________

Subscriber Employer: ______________________ *Employer #:* ______________________

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ______ Somewhat difficult ______ Very difficult ______ Extremely difficult ______

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

EPWORTH SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you "Have Not" done some of these recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number of each situation:

0 = No Chance of Dozing
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching T.V.	
Sitting inactive in a public place (e.g. movies / theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35kg/m2	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5-8
Intermediate risk of OSA: Yes 3-4
Low risk of OSA: Yes 0-2

EL PASO SLEEP CENTER

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of consultations / sleep study benefits to Dr. Gonzalo Diaz / El Paso Sleep Center For services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.
Yo, autorizo el pago por consultas o estudios del sueno a el Dr. Gonzalo Diaz / El Paso Sleep Center de su parte ya sea en persona o bajo su supervision. Yo entiendo que yo sere responsible por la porcion que mi aseguranza de salud no tiene cobertura.

AUTHORIZATION TO RELEASE INFORMATION

I, hereby authorize Dr. ____________________________ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
Yo, autorizo a el Dr. ______________________________ propocionar informacion medicas que sean necesarias para mi cuidado de salud o para procesar reclamos de aseguranza.

MEDICARE / MEDICAID

I, certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
Yo, certifico que toda la informacion que he proporcionado para el pago de mis servicios es veridico. Yo, autorizo proporcionar toda mi documentacion medica. Yo, autorizo el pago departe de mi aseguranza para el pago de mi cuidado.

AUTHORIZATION OF PATIENTS RELEASE OF INFORMATION

During the course of your treatment at the El Paso Sleep Center the doctor may prescribe a CPAP unit for your use at home. If the El Paso Sleep Center is not in the network for your particular insurance, the El Paso Sleep Center will forward your information to a medical equipment company to provide you with any medical equipment that may be necessary.

I authorize El Paso Sleep Center to release patient information to a medical equipment company that would be able to further assist me in regards of receiving the CPAP unit or any other medical supplies.

PLEASE PRINT

Patient Name: _____________________________________ Date: _________________________

Parent / Guardian: ________________________________ Date: _________________________

Signature: ____ Date: _________________________

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Notice of Privacy Practices

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.

Law Enforcements

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are acquired to report certain communicable disease to the state's public health department.

Appointment Reminders

Your health information will be used by our staff to send you appointment reminders, leave messages on voice mail and with family members.

Other Uses and Disclosures that Require Your Authorization

Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Modified F.O.S.Q.

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q3. Do you have difficulty operating a motor vehicle for <u>short</u> distances (less than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q4. Do you have difficulty operating a motor vehicle for <u>long</u> distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q7. Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q10. Has your mood been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Score	Patient Name: Last, First	D.O.B.	Today's Date: