WEST COAST PULMONARY
& SLEEP DISORDERS CENTER

Patient Information

Today's Date: _____ Referred by: _____

Name: _____ Last	_____ First	_ M.I.	*Spouse information* Name of spouse:
Address:			Social Security Number:
City:	**State:**	ZIP:	Date of birth (m/d/yy):
Birth Date:	Phone #:		Spouse's employer:
Age:	Cell phone #:		Employer's address:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Child			Business phone:
Social Security Number:			Cell phone #:
Employer:			Occupation:
Employer's address:			**Person to notify in case of emergency other than spouse:**
Business phone #:			
Occupation:			Relationship:
Responsible Party (if other than patient):			Address:
			Phone #:

Insurance Information (copies of card(s) required)

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
I.P.A./Medical Group:	I.P.A./Medical Group:
Insured's Name:	Insured's Name:
Insured's I.D. Number:	Insured's I.D. Number:
Group #:	Group #:

Authorization of Benefits to Physicians

I hereby authorize payment directly to West Coast Pulmonary Physicians, Inc. of the surgical and/or medical benefits, if any, otherwise payable to me for the services as described on the attached claim.

Authorization to Release Information

I hereby authorize West Coast Pulmonary Physician, Inc. to release any information acquired in the course of my examination or treatment.

_____ _____

Signed (insured person) Date (m/d/yy)

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Medical History

Name: _____ **Age:** ___ **Birthdate:** _____

Welcome to our office. This questionnaire is intended to help your doctor better understand your needs. If there are any questions you do not understand, please talk them over with us.

Name of doctor who referred you here: _____
Name of primary doctor: _____
Reason for your visit: _____

Medical Illnesses (please check)

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Valley fever
- ☐ Sleep apnea
- ☐ Pulmonary fibrosis
- ☐ Sinus infections
- ☐ Heart attack
- ☐ Heart failure
- ☐ Atrial fibrillation
- ☐ Colon problem
- ☐ Heartburn/reflux
- ☐ Ulcer
- ☐ Liver disease
- ☐ Cancer
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Blood clot on legs or lungs
- ☐ Epilepsy/seizure
- ☐ Stroke

Other:

Surgeries: _____

Allergies to medications: _____

Medications (include prescription and over-the-counter medicines)

Name	Dosage	How many times a day

Name	Dosage	How many times a day

Immunizations

Date of last flu vaccine (m/d/yy): _____ Date of last pneumonia vaccine: _____

Date of last PPD: _____ Positive or Negative: _____

Family History

	Medical Problems	Age at Death	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Child(ren)			

Any other blood relatives with lung problems? _____

Personal History

Birthplace: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Military service: ☐ Yes ☐ No If yes, where? _____

Occupation: _____

Highest level of school completed: _____

Exposed to: ☐ Fumes ☐ Dust ☐ Chemicals ☐ Mold ☐ Asbestos

Pets at home, including birds: _____

Smoking: ☐ Never smoked

If you did or do smoke, how many years? _____

When did you quit? _____

☐ Cigarettes How many packs per day? _____

☐ Cigars How many per day? _____

☐ Pipe

What treatments have you tried to quit smoking? _____

Alcohol: Do you drink alcohol? ☐ Yes ☐ No

Type: _____

Ounces per day/week: _____

Drugs: Have you used any drugs? ☐ Yes ☐ No

Type: _____

When did you quit? _____

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Review of Systems (please check)

General
- ☐ Fever
- ☐ Chills
- ☐ Sweats at night
- ☐ Fatigue

Sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Snoring
- ☐ Excessive daytime sleepiness
- ☐ Sleep apnea
- ☐ Witnessed apneas

Neurological
- ☐ Headaches
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Depression

Skin
- ☐ Rash
- ☐ Itching
- ☐ Loss of hair

Eyes
- ☐ Change in vision
- ☐ Pain in eyes
- ☐ Cataracts

Ears/Nose/Mouth
- ☐ Hard of hearing
- ☐ Runny nose
- ☐ Sinus problems
- ☐ Polyps in nose
- ☐ Sores in mouth
- ☐ Dental problems
- ☐ Hoarseness

Hematologic
- ☐ Anemia
- ☐ Bleeding or bruising easily

Gastrointestinal
- ☐ Lost weight recently
- ☐ Gained weight recently
- ☐ Loss of appetite
- ☐ Stomach pain
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in bowel movement
- ☐ Jaundice

Pulmonary
- ☐ Wheezing
- ☐ Coughing
- ☐ Phlegm
- ☐ Bloody phlegm
- ☐ Hoarse voice
- ☐ Shortness of breath

Cardiac
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankles swollen
- ☐ Wake up short of breath
- ☐ Fainting

Genitourinary
- ☐ Pain when urinating
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Trouble starting urine
- ☐ Nighttime urination
- ☐ Prostate problem

Bones/Joints
- ☐ Joints painful or swollen
- ☐ Muscle cramps
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis

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FINANCIAL POLICY

Please be assured that the physicians and staff of this practice are dedicated to providing medical care of the highest quality to all our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement. Failure by the insurance company to pay, results in the balance being transferred to the patient for payment. We thank you in advance for taking the time to review these policies. Please feel free to discuss any concerns or questions you may have with anyone of our billing staff or our Practice Manager. Although it is ultimately the patient's responsibility to understand the benefits of their own health plan, we would welcome the opportunity to assist you in understanding the complexities of health insurance today.

Things to bring with you to your initial visit:

- Current Health Insurance Card(s) - If we do not have a copy of your current insurance card(s), you may be asked to pay up front for the visit or reschedule to such a time that we have proof of your eligibility and coverage.
- Photo ID – This assists us in verifying identity and protecting patients against medical identity theft/fraud.
- Method of payment- Co-pays, deductibles, and other applicable out-of-pocket expenses are due at the time of services. If you do not have method of payment, your appointment will be rescheduled. For your convenience, we accept checks, credit cards, debit cards and cash.

Cash Pay/Fee for Service:

We offer a reasonable discount for cash pay/fee for services for patients who have no health insurance coverage. Prior to your visit, you will be provided an estimate of the visit cost and will be required to pay in full at time of check-in on the day of your appointment. In the event the physician carries out additional procedures/tests, you will be required to pay for these at the time of check-out.

Co-pays, Deductibles, and Co-Insurance:

- We are obligated to collect the co-pay at the time of your visit, even if you are sick. We are required to do so by your insurance plan. The co-payment amount is determined by the individual insurance policy.
- Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. If Verification of Deductible is unable to be made, payment of the full deductible is due at the time of service.

Patient Responsibility:

- It is the patient's responsibility to know and understand their insurance plan benefits, and what services their plan will not cover, as well as verify provider network participation.
- It is the patient's responsibility to provide current and correct insurance information, Failure to do so may result in the inability to collect from the insurance company, and the balance will be the patient's financial responsibility.

Insurance:

We are contracted with multiple insurers to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment, co-insurance, and deductible at the time of services.

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Out of Network:

If you have insurance coverage under a plan with which we do not have a contract, this is considered out of network. You are responsible to know If your plan has out of network benefits. As a courtesy, we will process your claims. You will be expected to pay any unsatisfied out of network deductible prior to your visit. If your out of network deductible exceeds our house charge, you will be expected to pay our cash price for the visit prior to receiving services. You will be expected to pay any outstanding amount after your plan adjudicates your claim and we have applied the payment received for your visit; you will be expected to pay upon receipt of your statement. Failure to do so may result in a collection referral.

Medicare:

Please make sure you have a full understanding of your Medicare benefits and what might be your responsibility if not covered by Medicare. We ask patients to sign an ABN whenever Medicare appears likely to deny payment for a specific service. Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for the bill.

Medi-Cal:

Eligibility is verified on a month-to-month basis. Please ensure that you bring your Medi-Cal card to every visit. In the event you do not bring your card, your visit may need to be re-scheduled until such a time that we have proof of your Medi-Cal eligibility and coverage.

HMO Insurance:

If you are enrolled in an HMO Plan (including Medi-Cal HMO Plans such as Clinicas Del Camino Real) a referral from your Primary Care Physician is required. It is the patient's responsibility to verify that a referral is in place before the visit.

Outstanding Balances/Collections:

- Prior to providing additional services to patients, payment in full of total outstanding balances will be required.
- We will make every effort to work with patients regarding outstanding balances and arranging payment plans when appropriate. It is the patient's responsibility to request assistance if they are unable to pay promptly. Unpaid balances that are greater than 90 days old will be referred to an outside collection agency.

Miscellaneous Fees:

- If for any reason you are unable to keep an appointment, please notify our office 24 hours in advance. There will be a $25.00 charge if a 24-hour notice is not received.
- There is a $25.00 fee for all returned checks.

Refunds:

Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full.

By signing below, you signify that you have read and understand the Financial Policies of West Coast Pulmonary & Sleep Disorders Center.

Print Name	Signature	Date

WEST COAST PULMONARY
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SLEEP QUESTIONNAIRE

Name: _____ Date: _____

My main sleep complaint is:

- ☐ Trouble sleeping at night
- ☐ Being sleepy all day
- ☐ Unwanted behaviors during sleep, explain: _____
- ☐ Other, explain: _____

USUAL SLEEP HABITS

Bedtime: _____ ☐ am/☐ pm
Wake time: _____ ☐ am/☐ pm

Number of awakenings: _____
Naps per week: _____
Duration of sleep problem: _____

DIRECTIONS: Check any statement which currently applies to you

- ☐ Unrefreshing naps
- ☐ Restless sleeper
- ☐ Stop breathing during sleep
- ☐ Awaken with headaches
- ☐ Have high blood pressure
- ☐ Cough up sputum or mucus at night
- ☐ Falling asleep at inappropriate times
- ☐ Refreshing naps
- ☐ Vivid dreams
- ☐ Paralysis or inability to move on awakening
- ☐ Eat excessive amounts of sweets or chocolates
- ☐ Driven miles past destination with little awareness
- ☐ Legs jerk during sleep
- ☐ Experience inability to keep legs still
- ☐ Trouble falling asleep
- ☐ Awaken long before it is necessary
- ☐ Sleep better I unfamiliar setting
- ☐ Light sleeper
- ☐ Function best in the evening
- ☐ Jaws ache in morning
- ☐ Bedwetting in adulthood
- ☐ Sudden awakening with intense anxiety or dread
- ☐ Late sleeper
- ☐ Bitter or sour mouth taste in morning
- ☐ Hiatal hernia
- ☐ Awaken with blood on the pillow
- ☐ Awaken with heartburn
- ☐ Very loud snorer
- ☐ Awaken with choking sensation
- ☐ Sweat a lot during sleep
- ☐ Difficulty waking in the morning
- ☐ Have gained more than 10 lbs. in the last year
- ☐ Unable to sleep in a flat position
- ☐ Driving accidents or near-accidents due to sleepiness
- ☐ Dream a lot
- ☐ Dreams or hallucinations while awake
- ☐ Sudden sensation of weakness in knees or legs
- ☐ Was a hyperactive child or teenager
- ☐ Kicking or twitching during sleep
- ☐ Experience restlessness, tingling or crawling in legs
- ☐ Sleep with ear plugs or eye shades
- ☐ Trouble returning to sleep
- ☐ Don't feel tired at bedtime
- ☐ Use sleeping pills
- ☐ Bed partner disturbs sleep
- ☐ Grind teeth in sleep
- ☐ Sleep walking as adult
- ☐ Banging, twisting or shaking head during sleep
- ☐ Shift-worker or night work
- ☐ Heart pain during the night
- ☐ Nocturnal seizures
- ☐ Awaken with back pain
- ☐ Bitten tongue during sleep

MEN

- ☐ Awaken with painful penile erections
- ☐ Have problems obtaining or maintaining erections

WOMEN

- ☐ Sleep problem varies with menstrual cycle
- ☐ Sleep problem started or got worse at menopause
- ☐ Currently taking birth control pills

FAMILY HISTORY

- ☐ A relative died of "crib death"
- ☐ Other family members snore loudly
- ☐ Other family members have sudden attacks of muscle weakness
- ☐ Other family members fall asleep during the day
- ☐ Other family members have the same sleep problem I do

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SPOUSE OR ROOMMATE QUESTIONNAIRE

Name of Patient: _____ Date: _____

Check any of the following behaviors that you have observed the patient doing while asleep.

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Twitching of legs or feet during sleep
- ☐ Pause in breathing
- ☐ Grinding teeth
- ☐ Sleep-talking
- ☐ Sleepwalking
- ☐ Bed-wetting
- ☐ Sitting up in bed but not awake
- ☐ Head rocking or banging
- ☐ Kicking with legs during sleep
- ☐ Getting out of bed but not awake
- ☐ Biting tongue
- ☐ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

Describe the sleep behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

If you have heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud “snorts”?

☐ Yes ■ No

Explain:

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STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP	Yes	No
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors?	☐	☐
Do you often feel **T**IRED, fatigues, or sleepy during daytime?	☐	☐
Has anyone **O**BSERVED you stop breathing during your sleep?	☐	☐
Do you have, or are you being treated for, high blood **P**RESSURE?	☐	☐

BANG		
BMI more than 35kg/m^2?	☐	☐
AGE over 50 years old?	☐	☐
NECK circumference > 16 inches (40cm)?	☐	☐
GENDER: Male?	☐	☐

TOTAL SCORE _____