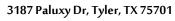


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Child Registration Form

Patient Last Name:	First Name:	DC)B:	Sex:
Address:	City: _		State:	Zip:
Home Phone:	Cell Phone:	Parent/Guard	dian Phone: _	
E-mail address (required):		Social Securi	ty Number: _	
Primary Care Physician Name	o:	City:	S1	tate:
Referring Physician Name:		City:	S	tate:
Emergency Contact Name:		Date of Bir	th:	Sex:
Emergency Contact Phone nu	mber:	Relationship to Pati	ient:	
Ethnicity: Hispanic or Latine	o / not Hispanic or Latino / prefer not	to answer Lang	uage: Englis	h / Spanish /Other
Race: American Indian / Asia	an / African-American / Caucasian / H	awaiian / Pacific Isla	nder / Refuse	e to answer
	tedicine Institute of Texas? (Chec ite / Facebook / Billboard / Primary ca		st / family an	d friends
Primary Insurance Inform	nation:			
Insurance carrier Name:	ID:		Grou	p:
Subscriber Name:	Date of	Birth:	Relatio	onship:
Secondary Insurance Info	ormation:			
Insurance carrier Name:	ID:		Grou	p:
Subscriber Name:	Date of	Birth:	Relatio	onship:
Medical Consent: I volunta	rily consent to medical treatment at Sl	eep Medicine Institut	e of Texas	
professional services rendered.	I do hereby assign payment directly to SI understand that I am financially responsion as may be necessary for purpose of treance with state and federal laws.	sible for any charges r	not covered by	my insurance. I also
graduate of a certified training supervision of the physician, the maintenance care. "Supervision" of and accepting responsibility f	s has on staff Nurse Practitioners who assi program including eight years of RN. BS: e Nurse Practitioner can diagnose, treat at does not require the physical presence of t for the medical services provided. I have needs as and when needed. I understand the	N and MSN and is lice and monitor common ac the supervising physicial read the above and her	ensed by the st cute, chronic co in but rather ov eby consent to	tate board. Under the onditions and provide verseeing the activities of the services of nurse
By signing below I am verifying the	he personal data on this sheet is accurate a	nd indicating I understa	and the informa	ation provided.
Patient/guardian Signatu	ıre:	Date: _		
A valid photo ID is required for	or the patient (if applicable) and/or the	parent/guardian.		





Ph: 903-787-7533;

Fax:903-787-8825

Financial Policy

Patient Last Name:	First Name:	DOB:
Thank you for choosing Sleep Medicine Insuccessful. Please read the following financially understand our policy.		r. We are committed to your treatment being ve any questions as we would like you to
<u>PAYMENTS:</u> Payment is expected at the ti not carry insurance, or if your health insur payment in full is expected at the time of o	ance has sleep medicine exclusions	check and all major credit cards. If you do , or a pre-existing condition clause exclusion,
APPOINTMENTS, NO-SHOW AND CANC you keep your appointment time. If you are hours in advance so that we may open that	e unable to keep your appointment,	· 1
NO-SHOW fee: Please be aware that there cancel/reschedule. All sleep tests are subjective within 48 hours of your sleep study test or	ect to \$100.00 fee per sleep study ap	
TREATMENT FOR MINOR: As an adult ca for all services rendered at Sleep Medicine		or treatment I am responsible for payment
INSURANCE AND PAYMENT FOR OFFICE information card and ID card and update uthat Dr. R. V. Ghuge and Sleep Medicine In	ıs on any changes in your healthcar	e plans. It is your responsibility to make sure
Co-pays, deductible and co-insurance amo company you will be required to pay the co- company does not pay the practice within a your insurer, we will refund any overpaym violation of your financial responsibility was	o-pay, co-insurance, deductible and a reasonable period of time, you wil ent due to you. Failure to pay your	out of pocket expenses. If your insurance l be billed. If we later receive payment from
RETURNEDCHECKS: You will be required	d to pay by cash or money order to o	cover the charges along with the \$25 fee.
I will be charged \$25 if my check is non-payment, I will be charged a collection		understand that if my bill is turned over for
Part 9, Chapter 165, Section 65.2, Base me page for every copy thereafter. Postage is a	dical records copy charges re \$25 for additional and payment is required in the records before making them availables thas been received and after patient	arges, Texas Administrative Code. Title 22, or the first twenty (20) pages, and \$0.50 per in advance. Sleep Medicine Institute of Texas able for patient to pick up, and these 15days has signed the form authorizing records
which are applied to the corresponding date	tes of service. I have read and under	harges first, except for insurance payments rstand the practice's financial policy and I ay be amended by the practice from time to
Name of Responsible Party:	Relation	onship to Patient:
Responsible Party signature:	Date: _	



Authorization for Release of Protected Health Information

Patient Last Name:	First Name:		DOB	:
I understand that it is the policy of Sleep Med Information. In addition to the caregiver(s) p claim, I would like for the following person/p	roviding health se	ervices, and my i	nsurance company	(-ies) for payment of my
Name	Date of Birth	Clinical Information	Financial Information	Restricted Information
ACCESS	O RESTRIC	 	MATION	
If you do not wish to share specific clinical clinical information you DO NOT WISH Sexually transmittMental/behavioraTerminal IllnessPregnancyOther COMMUNICATION: Please initi I hereby give consent to confidential and including appointment reminders, referr Insurance Referrals: Please initial I am responsible for getting a referral fro requires a referral to see a specialist. Fail a reduced rate or not paid at all. I would	to share: ted diseases l health al here clinical informa als, billing and i here m my Primary c ure to obtain a r then be responsi	ntion being e-m nsurance infor eare physician p referral will cau ible for the amo	ailed to me or lef mation. orior to my first v se my insurance ount not paid by i	it on my voicemail isit if my insurance benefits being paid at insurance
ACKNOWLEDGEMENT OF RECOME I have received a copy of the Sleep Medicine Sleep Medicine Institute of Texas has the that I may contact Sleep Medicine Institute Privacy Practices.	ine Institute of 7 right to change	Texas Notice of its Notice of P	Privacy Practices fivacy Practices fi	s. I understand that rom time to time and
Patient/ Guardian signature	-		Date	
Staff/ Witness signature	_		Date	



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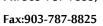
Sleep Medicine Institute

Children's Sleep Questionnaire

Patient Last Name:	First Name:		Today's Date:		
Date of Birth: Gender:	Gender: Height (inches)		Weight (pounds)		
Patient isoldest of	siblings.				
Referring Doctor's Name:					
Referring Doctor's address:	City	State:	Zip		
Was your child born prematurely? Yes / No	If yes, How many weeks? _				
Has your child ever been hospitalized? Yes / No	If yes where? When?				
For what diagnosis?					
Family History: (mark all that apply and relatio	onship to patient)				
Condition	Relationship				
Obstructive Sleep Apnea					
Anxiety					
Depression					
High Blood pressure/ heart disease					
Hypertension					
Diabetes					
Snoring					
Insomnia					
Hypersomnia/ excessive daytime sleepiness					
Narcolepsy					
Restless Leg Syndrome					

Child's Past Medical history: (mark all that apply)

Attention Deficit Disorder (ADD/ADHD)	Gastroesophageal reflux disease (GERD)
Allergies	Genetic disorders
Autism	High blood pressure
Anxiety	Heart disease
Cerebral palsy	Learning disability
Chronic sinusitis	Obesity
Chronic bronchitis	Obsessive Compulsive Disorder
Depression	Obstructive sleep Apnea
Drug abuse/ dependency	Speech disorder
Delayed milestones	Sinus problems
Ear Infections	Seizures
Other:	





Child's Sleep History:

Condition	Yes / No	Condition	Yes / No
A. Breathing While Asleep: Does your child:		B. Breathing, other: Does your child:	
I. Snore half the time?		1. Breath mostly by mouth when awake?	
2. Always snore?/ snore loudly?		2. Have a dry mouth on waking up?	
3. Cough frequently?		3. Have frequent ear infections?	
4. Have heavy/loud breathing?		4. Have frequent colds (URI's)?	
5. Gasp for air?		5. Get ill frequently?	
6. Make choking sounds?		6. Wheeze?	
7. Sound congested?		7. Stop breathing and trying to breathe?	
8. Stop breathing but try to?		8. Breath mostly by mouth?	
C. Schedule: What time does your child:			
1. Go to sleep, if school is the next day?		am/pm	
2. Go to sleep, if NO school, or NO pre-school?		am/pm	
3. Awaken, if school day?		am/pm	
4. Awaken, if NO school or pre-school? .		 am/pm	
5. How many hours does your child sleep on school nig	ghts?		
6. How many hours does your child sleep on non-scho	ol or pre-s	chool nights?	
7. Nap weekdays?		If yes, for how long?	
8. Nap weekends?		If yes, for how long?	
9. Appear to be the most alert? morning / mid-			
day / afternoon / evening / night			
D. Other Sleep Problems: Does your child have:			
1. Night terrors		9. Night sweats	
2. Frightening dreams		10. Twitching of legs	
3. Bedwetting		11. Wake up during the night	
4. Head banging		How many times a night	
5. Body rocking		For how long	
6. Tooth grinding		What time of the night	
7. Sleepwalking		12. Headaches upon awakening	
8. Blood on the pillow		13. Become fearful at bedtime	
		14. Awaken in a panic	
E. Daytime sleepiness in SCHOOL AGE CHILDREN: Does your child:			Yes / No
1. Complain of feeling tired (wish to be inactive)?			
2. Have problems with daytime sleepiness?			
3. Has a teacher or caretaker said your child appears e	xcessively	sleepy?	





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4. Have difficulty waking up?	
5. Wake up feeling unrefreshed?	
6. Have trouble getting dressed in the mornings?	
7. Have no appetite in the morning?	
8. Seem groggy in the morning?	
9. Have difficulty going to sleep?	
F. Narcolepsy in SCHOOL AGE CHILDREN: Does your child:	Yes / No
1. Ever have sleep attacks, or suddenly and unexpectedly fall asleep?	
2. Become weak, especially when excited, angry or laughing?	
3. Have vivid dreams when falling asleep or taking a nap?	
4. Fall asleep at school?	
5. Fall asleep in odd situations or places?	
6. Imagine seeing things before falling asleep?	
7. Experience brief moments of paralysis?	
G. Behavioral, in SCHOOL AGE CHILDREN: Does your child	Yes / No
1. Have behavioral problems?	
2. Do more poorly at school than expected?	
3. Seem Hyperactive?	
4. Not listen when spoken to?	
5. Become easily distracted?	
6. Fidget or squirm excessively?	
7. Become easily upset?	
8. Seem very sensitive?	
9. Worry excessively?	
10. Seem excessively anxious?	
11. Have problems relating to children the same age?	
12. Have no close friends (who are the same age and not a family member)?	
13. Have difficulty organizing tasks and activities?	
14. Stay "on the go" or act as if "driven by a motor"?	
15. Interrupt or intrude on others (interrupt conversation or games)?	
16. Uses electronic gadgets in bed? (smart phone, e-book, smart pad etc)	
17. Sleep with pet in the bed?	
18. Listen to loud music of play video games before going to bed?	
Questionnaire completed by:	