

Please bring the following items to your visit:

- **This form filled out.**
- **Insurance referral if needed. If you are unsure whether or not you need a referral, please contact your primary care physician or insurance company well before your appointment date.**
- **Your health insurance card(s) and prescription drug card(s).**
- **CPAP equipment - mask, tubing, CPAP unit, power cord, and humidifier (remember to empty the water chamber before transporting).**

Virginia Prescription Monitoring Program

The prescription monitoring program collects prescription data for Schedule II-IV drugs into a central database which can then be used by limited authorized users to assist in deterring the illegitimate use of prescription drugs. The information collected in this program is maintained by the Department of Health Professions, and strict security and confidentiality measures are enforced. Only those persons authorized by law can be provided information from the database, and the list of authorized persons is very limited. Prescribers and dispensers may query the database to assist in determining treatment history and to rule out the possibility that a patient is "doctor shopping" or "scamming" in order to obtain controlled substances.

Pharmacies, non-resident pharmacies, permitted physicians, and physicians holding a permit to sell controlled substances are required to report all dispensing of any Schedule II, III, and IV controlled substances to the PMP.

Sleep Disorders Center of Virginia may utilize the Prescription Monitoring Program to obtain patient histories.



PATIENT INFORMATION

If you have not completed this form within the past year, or if your information has changed please complete the patient information page. We do this in an effort to keep your records as current as possible.

If the patient is a minor, guardian information MUST be completed.

Date Completed: _____/_____/_____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Race: Hispanic Asian Caucasian Black or African American Native American Multiracial Pacific Islander Other
Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

Preferred Language: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Extension: _____

Other Phone: (_____) _____ - _____

E-Mail: _____@_____._____

Marital Status: _____

Spouse/Significant Other's Name: _____

Spouse/SO's Phone: (_____) _____ - _____

To Protect Your Privacy

When your sleep doctor calls with **test results**, at which number do you prefer to be called during the day?

Home Work Mobile Other: _____

Which number do you prefer we use for **appointment reminders**?

Home Work Mobile Other: _____

May we send postcards in the mail to remind you of upcoming appointments or other related information? Yes No

May we send you e-mail you reminders for upcoming appointments and other appointment related information? Yes No

Is there a spouse, significant other, family member, or other person who has your permission to discuss your diagnosis and treatment with your sleep doctor? Yes No

Please write the name of any person who has your permission to discuss your diagnosis and treatment with Sleep Disorders Center of Virginia, starting with your spouse/significant other if applicable. This permission shall remain in effect until revoked by you. You have the right to revoke permission at any time.

Name	Relationship to You
	Spouse/Significant Other

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GUARDIAN INFORMATION

ALL MINORS MUST HAVE THIS FORM COMPLETED

If you have not completed new guardian information in the past 6 months (if applicable) please fill out the following personal information. We do this in an effort to keep records as current as possible.

If some information is the same as the patient's, please write "same" in blank.

Today's Date: _____ / _____ / _____
 Patient Name: _____
 Legal Guardian Name: _____
 Relationship to Patient: Parent
 Other Family Member:
 Legal Guardian – Please present documentation to front desk

Guardian Street Address: _____
 Guardian City: _____ State: _____ Zip: _____
 Guardian Home Phone: (____) _____ - _____
 Guardian Work Phone: (____) _____ - _____ Extension: _____
 Guardian Mobile Phone: (____) _____ - _____

Does the minor patient reside in a group/facility home or hospital? Yes No – sign bottom and continue next page
 If yes, please provide the name of the facility or hospital: _____

Facility Address: _____
 Facility City: _____ State: _____ Zip: _____

As the minor's legal guardian, I grant access to medical information as stated below, for the following group home / facility employees.

Group Home / Facility Employee Names: _____

- These employees have permission to:
- Enter exam room with patient if needed
 - Discuss medical information and test results with SDC physicians and staff
 - Request and receive copies of the minor patient's medical records
 - Discuss billing issues with SDC staff

Parent/Guardian Signature: _____

PLEASE NOTE: If the legal guardian is not a biological parent, you must present legal documentation to the front desk. This ensures the proper parties will have access to records as needed.

If the patient lives in a group home, facility, or hospital setting, employees of the facility do not have access to medical records and/or information unless written permission is given by the legal guardian. Please bring documentation to your first appointment.

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INSURANCE INFORMATION

If you have not completed this form within the past year, or if your information has changed please complete the patient information page. We do this in an effort to keep your records as current as possible. All fields are REQUIRED by your insurance company before payment will be considered.

Date completed: ____/____/____

PRIMARY INSURANCE

Name of Primary Insurance: _____

Policyholder Name: _____

Your Relationship to Policyholder: Self Spouse Parent Other:_____

Policyholder Date of Birth: _____

Policyholder Social Security: _____

Policyholder Sex: Female Male **Policyholder** Phone: _____

Policyholder Employer: _____

Policyholder Occupation: _____

Policyholder Employment: Part-Time Full-Time

SECONDARY INSURANCE

Name of Primary Insurance: _____

Policyholder Name: _____

Your Relationship to Policyholder: Self Spouse Parent Other:_____

Policyholder Date of Birth: _____

Policyholder Social Security: _____

Policyholder Sex: Female Male **Policyholder** Phone: _____

Policyholder Employer: _____

Policyholder Occupation: _____

Policyholder Employment: Part-Time Full-Time

MEDICARE Patients:

If **Medicare is secondary**, please check the reason below.

- Working Aged Beneficiary or Spouse with Employer Group Health Plan
- End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
- No-fault Insurance including Auto is Primary
- Worker's Compensation
- Public Health Service (PHS) or Other Federal Agency
- Black Lung
- Veteran's Administration
- Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- Other Liability Insurance is Primary

IF YOU HAVE A TERTIARY INSURANCE, PLEASE USE A SEPARATE SHEET AND INCLUDE INFORMATION ABOVE. THANK YOU!

Office Staff - Scan as INSURANCE UPDATE FORM document type



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CPAP CLINIC PATIENT QUESTIONNAIRE

CURRENTLY, how likely are you to fall asleep in the following situations?
Please use the scale below to estimate.

Table with 5 columns: Situation, would NEVER dose, slight chance of dozing, moderate chance of dozing, high chance of dozing. Rows include: Sitting and reading, Watching TV, Sitting, inactive in a public place, As a car passenger, Lying down to rest, Sitting and talking, Sitting quietly after lunch, In a car in traffic.

Please list your current medications: [] None

Please list your current medication allergies: [] None

Smoking Status: [] Current every day smoker [] Never smoker
[] Current some day smoker [] Former smoker

OFFICE USE ONLY:

Weight _____ lb.

Initials _____

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