MICHELLE ZETOONY, DO, FCCP, FACOI
DO SLEEP SOLUTIONS

*Account#*_____ ***PATIENT INFORMATION***

Patient Name: _____ **DOB:** ___/___/_____ **SS#:** _____-_____-_____ **Sex: Male** ___ **Female** ___

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone#: (_____)_____ **Cell#** (_____)_____

Email:_____ ☐ **Check this box if we may use this cell # for text and/or robocall appointment reminders**

Nationality: ☐**African American/Black** ☐**American Indian or Alaska Native** ☐**Asian** ☐**Native Hawaiian or Other Pacific Islander** ☐ **White**

Ethnicity: ☐**Hispanic** ☐**Non-Hispanic** ☐**Declined**

Marital Status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Seperated** ☐**Partnership**

Primary Care Provider: _____ **Primary Care Provider's Phone:** (___) _____-_____

Pharmacy :_____ **Pharmacy Phone:** (___) _____-_____ **Pharmacy Cross Streets:** _____

Smoker? ☐**Current Smoker** ☐**Former Smoker** ☐**Never Smoked**

Primary Language:_____ **Preferred method of contact: Email Phone Cell Phone Text**
(Please Circle One)

Whom may we thank for referring you:_____

Employer Status: ☐**Employed** ☐**Self-Employed** ☐**Retired** ☐**Disabled** ☐**Unemployed** ☐**Student**

Occupation:_____ **Employer**_____

Employer Address_____ **Work Phone:** (_____)_____

EMERGENCY CONTACTS

#1. Name: _____ **Relationship:** _____ **Phone#:** (___) _____-_____

#2. Name: _____ **Relationship:** _____ **Phone#:** (___) _____-_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ **Policy#**_____ **Group#**_____

Policyholder's Name: _____ **Date of Birth**_____

Policyholder's SS#:: _____ **Relationship to patient:** _____

Claims Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Eligibility Phone# (_____) _____-_____

Secondary Insurance Carrier: _____ **Policy#**_____ **Group#**_____

Policyholder's Name: _____ **Date of Birth**_____

Policyholder's SS#:: _____ **Relationship to patient:** _____

Claims Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Eligibility Phone# (_____) _____-_____

MICHELLE ZETOONY, DO, FCCP, FACOI

REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider, which may include but are not limited to labortory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services endered to the patientunder the general and special instructions of thepatient's physician. DO Sleep Solutions, Inc., has the right to refuse to you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Patient Signature_____ **Date**_____

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to DO Sleep Solutions, Inc., for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made

Patient Signature_____ **Date**_____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient Signature_____ **Date**_____

Health Insurance Portability and Accountability Act

What is HIPAA?

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

- Provides the ability the transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information

I have been offered or received a copy of the HIPAA form by DO Sleep Solutions,Inc. I have been asked to review the information and given opportunity to ask questions if i am unclear about the meaning of the information.

_____ _____

Patient Name Date

E-medication History Download

The Medication History service allows prescribers and pharmacies to use the Surescripts network to access a patient's Medication History across provider, at the point of care. This service can be used in the course of providing routine care, as well as during emergencies (like natural disasters). In both cases, Medication History enables healthcare providers to make a more informed clinical decision. To provide this service, Surescripts security connects to a patient's medication history data stored in the database of community pharmacies and pharmacy benefit managers. Surescripts requires patient consent as part of the process a prescriber must go through each each time they electronically access a patient's medication history. If a request for medication history is sent to Surescripts and the patient consent flag is not set,Surescripts rejects the request.

I hereby provide DO Sleep Solutions,Inc., the ability to download my complete Medication History from the nationwide database of pharmacies.

_____ _____

Patient Name Date

MICHELLE ZETOONY, D.O., F.C.C.P., F.A.C.O.I.
PATIENT MEDICAL HISTORY

Date: ____/____/_____

Patient Name: _____Gender: M F DOB: _____ Age: _____

Height: _____ Weight: _____

Past Medical History (Please answer all questions to the best of your ability):

Do you now or have you ever had:

	Yes	No		Yes	No
Tuberculosis (TB)			Thyroid disease		
Cancer			Stomach disease (includes ulcers acid reflux)		
High blood pressure			Intestinal disease		
Diabetes (blood sugar high or low)			Liver disease		
Heart Attack			Seizures		
Kidney Disease			Urinary issues		
Lung Disease			Other:		

Please explain all "Yes" answers:

_____

Habits:
Do you know or have ever used:
appt.)
1.) Tobacco (cigarettes, chew, pipes, etc.) Y N
If yes, how long?_____years. Quit? Y N
2.) Alcohol (beer, liquor, wine, etc.) Y N
If yes, How long?_____years. Quit? Y N
3.) Caffeinated beverages (soda, coffee, tea, energy drinks, etc.) Y N
How many per day?_____
4.) Illicit drugs (injected, inhaled, other, etc.) Y N
If yes, how long?_____years. Quit? Y N

Medication Allergies and reaction:
1.)
2.)
3.)
4.)
5.)

Food or environmental allergies:
1.)
2.)
3.)
4.)
5.)

Prior surgeries and dates:
1.)
2.)
3.)
4.)
5.)

Medications:Please list all medications you are currently taking including over the counter.(you can bring packages/bottles to

1.)
2.)
3.)
4.)
5.)
6.)
7.)
8.)
9.)
10.)
11.)
12.)
13.)
14.)
15.)
16.)
17.)
18.)
19.)
20.)

Michelle Zetoony, D.O., FCCP, FACOI

THE EPWORTH SLEEPINESS SCALE

Name _____ Date _____

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO JUST FEELING TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO WORK OUT HOW THEY WOULD AFFECT YOU. USE THE FOLLOWING SCALE TO CHOOSE ***THE MOST APPROPRIATE*** NUMBER FOR EACH SITUATION.

0=WOULD NEVER DOZE

1=**SLIGHT** CHANCE OF DOZING

2=**MODERATE** CHANCE OF DOZING

3=**HIGH** CHANCE OF DOZING

SITUATION	CHANCE OF DOZING
1. SITTING AND READING	0 1 2 3
2. WATCHING TELEVISION	0 1 2 3
3. SITTING INACTIVE IN A PUBLIC PLACE	0 1 2 3
4. AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	0 1 2 3
5. LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	0 1 2 3
6. SITTING AND TALKING TO SOMEONE	0 1 2 3
7. SITTING QUIETLY AFTER LUNCH WITHOU ALCOHOL	0 1 2 3
8. IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	0 1 2 3

TOTAL _____

DO SLEEP SOLUTIONS, Inc.
Michelle Zetoony, DO

A good sleep is important to your well-being. Since most people spend roughly one-third of their lives asleep, it's easy to see how the quality of sleep directly affects the quality of your life. 1 in 3 Americans has a sleep disorder which makes sleeping or waking hours miserable. Many of these people suffer needlessly because they are unaware that a problem exists. Once detected, most sleep disorders can be corrected. **If you have experienced any of the following symptoms in the last year, check the box YES. When referring to night, assume that this means during sleep.**

Section 1:	**YES**	**NO**
1. I have difficulty falling asleep.		
2. Thoughts race through my mind and this prevents me from sleeping.		
3. I feel afraid to go to sleep.		
4. I wake up during the night and have trouble falling back asleep.		
5. I worry about things and have trouble relaxing.		
6. I wake up earlier in the morning than I would like.		
7. I lie awake for 30 minute or more before I fall asleep.		
8. I feel sad and depressed.		
Section 2:	**YES**	**NO**
9. I have been told that I snore.		
10. I have been told that I stop breathing sometimes when I sleep.		
11. I have been told my blood pressure is high.		
12. I have been told by friends/family that my personality has changed.		
13. I am gaining weight.		
14. I feel that I sweat more than I should at night.		
15. I have notice my heart pounding during the night.		
16. I get morning headaches.		
17. I have trouble sleeping when I have a cold.		
18. I wake up suddenly some night gasping for breath.		
19. I am overweight.		
20. I am losing my sex drive.		
21. I feel sleepy during the day even when I sleep through the night.		
Section 3:	**YES**	**NO**
22. I have a chronic cough.		
23. I have to use antacids (Tums, Alka-Seltzer, etc) at least once a week for stomach trouble.		
24. I have morning hoarseness or get sore throats.		
25. I wake up night coughing or wheezing.		
26. I wake up at night needing to catch my breath or with chest pain.		

NAME: _____ Date: _____

NAME: _____ DOB _____

Section 4:	YES	NO
27. I have had trouble concentrating in school/work.		
28. When I am angry or surprised, I feel like I'm going limp.		
29. I have fallen asleep while driving.		
30. I feel like I go around in a daze.		
31. I have experienced vivid dream-like scenes upon falling asleep/waking.		
32. I have fallen asleep during physical effort (eating meal, exercise, etc).		
33. I feel like I am hallucinating when I fall asleep.		
34. I like to cram a full day into every hour to get everything done.		
35. I have fallen asleep when laughing or crying.		
36. No matter how hard I try to stay awake, I fall asleep anyway.		
37. I sometimes feel like I am unable to move waking up or falling asleep.		
Section 5	**YES**	**NO**
38. Other than when exercising, I still experience muscle tension in my legs.		
39. I have noticed (or others comment) that parts of my body jerk.		
40. I have been told that I kick at night.		
41. I experience aching/"crawling" sensations in my legs.		
42. I experience leg pain during the night.		
43. Sometimes I can't keep my legs still at night. I just **have to** move them.		
44. I awaken with sore or achy muscles.		

Questions about your habits:

WEEKDAY: BEDTIME: _____ WAKE UP: _____ NAPS: _____

WEEKEND: BEDTIME: _____ WAKE UP: _____ NAPS: _____

WORK HOURS: I WORK SHIFTS: YES NO

Please provide the information for the following procedures if they apply.

~Chest X-ray/CT? Y N
If yes, where and when._____

~Pulmonary function test/Spirometry/ 6MW? Y N
If yes, where and when._____

~Sleep studies (in lab or home)? Y N
If yes, where and when._____

**If you are currently using a BIPAP/ CPAP machine please bring your COMPLIANCE DOWNLOAD CARD to your appointment.

Are you currently affiliated with a Durable Medical Equiptment company? Is yes, please provide the name._____

Cancellation/ No show Policy

The cancellation/ no show policy is a courtesy to our office and patients. Cancelling or rescheduling an appointment **MUST** be done **24 hour prior** to your appointment time. Per office policy no show/ no call appointments and appointments not rescheduled 24 hour prior are subject to $50 fee. Do sleep Solutions reserves the right to decline any future appointments after two occurrences if no payment arrangements have been made.

Notice

Please be courteous to the office and it's patient and arrive promptly at your scheduled appointment time. Appointments that are more than 10 min late are subject to be rescheduled.

Thank you for your understanding!
~DO Sleep Solutions Staff

****Please print, sign and date below acknowledging you understand the guidelines of this policy. ****

Print Name: _____

Signature: _____ Date: _____