

Greater Corona Sleep Diagnostics

341 MAGNOLIA AVE. SUITE.203 CORONA, CA 92879

Phone: (951) 735-9211 Fax: (951) 735-1425
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REQUEST FOR SLEEP STUDY

DATE	LAST NAME		FIRST NAME	
AGE	SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	HEIGHT (FEET, INCHES)		WIEGHT LBS.

REASON FOR SLEEP STUDY: SLEEP MEDICINE CONSULTATION:

R/O SLEEP DISORDERED BREATHING/OBSTRUCTIVE SLEEP APNEA OR:

BRIEF HISTORY:

NEED ASSISTANCE: <input type="checkbox"/> DISABLE <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> OXYGEN <input type="checkbox"/> CHILD <input type="checkbox"/> HEARING IMPARED <input type="checkbox"/> SIGHT IMPARED <input type="checkbox"/> OTHER
PAST MEDICAL HISTORY <input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> CORONARY ARTERY DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> OTHER
EXPLAIN: _____
MEDICATIONS: _____

SLEEP AID <input type="checkbox"/> ZOLPIDEM 10MG BY MOUTH AT BEDTIME <input type="checkbox"/> ZOLPIDEM 5MG BY MOUTH AT BEDTIME <input type="checkbox"/> OTHER _____
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PLEASE FAX PATIENT INSURANCE CARD ALONG WITH DEMOGRAPHIC

TO: (951) 735-1425

THANK YOU!

M.D. SIGNATURE _____

PHONE NO. _____

Patient Information Sheet

Greater Corona Sleep Diagnostics^{*}

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INSTRUCTIONS:

1. Please print clearly and complete all information.
2. Please furnish a copy of your insurance card (front & back).

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PATIENT TO COMPLETE

LAST NAME		FIRST NAME		MIDDLE INITIAL		
ADDRESS (NUMBER, STREET)			CITY		STATE	ZIP CODE
HOME TELEPHONE ()		WORK TELEPHONE ()			DATE OF BIRTH (MM-DD-YY)	
SEX: MALE	FEMALE	SOCIAL SECURITY NO.			MARITAL STATUS	
<input type="checkbox"/>	<input type="checkbox"/>					
EMPLOYER				OCCUPATION		
EMPLOYER ADDRESS				EMPLOYER PHONE NO. ()		

PERSON/FAMILY MEMBER TO CONTACT IN CASE OF EMERGENCY

PRIMARY CARE PHYSICIAN		PCP TELEPHONE NO. ()		PCP ADDRESS	
REFERRING PHYSICIAN, IF DIFFERENT		REFERRING PHYSICIAN TELEPHONE NO. ()		REFERRING PHYSICIAN ADDRESS	
FAMILY MEMBER OR FRIEND		HOME TELEPHONE NO. ()		WORK TELEPHONE NO. ()	
RELATIONSHIP TO PATIENT		ADDRESS			

ELIGIBILITY GUARANTEE SECTION

PRIMARY INSURANCE NAME		POLICY/CERTIFICATE NO.		GROUP NO.	
PRIMARY INSURANCE PHONE NO ()		PRIMARY INSURANCE ADDRESS			
SECONDARY INSURANCE NAME		POLICY/CERTIFICATE NO.		GROUP NO.	
SECONDARY INSURANCE PHONE NO ()		SECONDARY INSURANCE ADDRESS			

I HEREBY AUTHORIZE GREATER CORONA SLEEP DIAGNOSTICS TO CONTACT MY INSURANCE COMPANY TO VERIFY MY COVERAGE. I UNDERTAND THAT IF I AM NO ELIGIBLE, I AM LIABLE FOR ALL CHARGES RENDERED. I AGREE THAT IF THIS INFORMATION IS NOT TRUE, I (OR THE ABOVE PERSON NAMED FINANCIALLY RESPONSIBLE FOR ME) WILL PAY IN FULL ALL SUCH CHARGES. I ALSO AUTHORIZE GREATER CORONA SLEEP DIAGNOSTICS TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO: GREATER CORONA SLEEP DIAGNOSTICS

SIGNATURE OF PATIENT

SIGNATURE OF INSURED (IF DIFFERENT)

DATE SIGNED

QUESTIONNAIRE FORM

Phone: (951) 735-9211
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DATE	LAST NAME	FIRST NAME
D.O.B.	SEX: MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	HEIGHT (FEET, INCHES) WIEIGHT <div style="text-align: right;">LBS.</div>

	YES	NO	OCCASIONALLY
Do you have difficulty falling asleep at the beginning of the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty staying asleep throughout the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times do you wake up during the night? _____			
How long does it take you to fall back to sleep? _____			
Do you experience a restless sensation in your legs while lying in bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how frequently: 25% 50% 75% Almost every night			
Have you been told that you make kicking/twitching movements while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how would you rate the severity: Mild Moderate Severe			
have you been told that you have pauses in your breathing while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience excessive daytime tiredness during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get drowsy while driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you occasionally awaken feeling paralyzed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience sudden loss of strength in your legs/arms during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are those brought on by a sudden frightening event or laughter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU FREQUENTLY WAKE UP WITH: (CHECK THAT APPLY)

DRY MOUTH
 HEADACHE
 EXCESSIVE SWEATING
 CHOKING OR GASPING
 NASEL CONGESTION
 CHEST PAIN
 HEART BURN

HOW LIKELY ARE YOU TO FALL ASLEEP DURING THE DAY IN THE FOLLOWING SITUATIONS, IN CONTRAST TO JUST FEELING TIRED?
 0=WOULD NEVER DOZE / 1=SLIGHT CHANCE / 2=MODERATE CHANCE / 3=HIGH CHANCE

<u>SITUATION</u>	<u>CHANCES OF FALLING ASLEEP</u>
SITTING AND READING	0 1 2 3
WATCHING TV	0 1 2 3
SITTING INACTIVE IN A PUBLIC PLACE (I.E. MOVIE THEATER)	0 1 2 3
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	0 1 2 3
LYING DOWN TO REST DURING THE DAY WHEN CIRCUMSTANCES PERMIT	0 1 2 3
SITTING AND TALKING TO SOMEONE	0 1 2 3
WHILE IN A CAR THAT IS STOPPED	0 1 2 3
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	0 1 2 3