Southwest Pulmonary & Sleep Disorders
Mauricio A. Reinoso MD — Sleep Disorders, Pulmonary & Critical Care
16605 Southwest Frwy, Suite 310
Sugar Land, TX 77479
Phone: 281-980-1330 Fax: 281-980-1331

Patient Information

Today's Date: ______________________________
Name: ____________________________________ Date of Birth: ______________________________
Mailing Address: ____ Unit / Apt #: _______________
City: ______________________________ State: ________ Zip Code: _________________________
Home Phone: _____________________________ E-mail: _____________________________________
Work Phone: _____________________________ Employer: ___________________________________
SSN#: __________________________________ Driver's License#: ____________________________

Emergency Contact Person (not living with you): ____
Relationship: _____________________________ Phone Number: ________________________________

Pharmacy Name: ___________________________ Pharmacy Phone #: ___________________________

Insurance Information

Primary Insurance Coverage: ____
Claims Mailing Address: ____
Insurance Company Phone: ____
Policy #: ________________________________ Group #: _______________________________________
Policy Holder's Name: ______________________ Policy Holder Date of Birth: _____________________
Policy Holder's SSN#: ______________________ Relationship to Patient: _________________________
Policy Holder's Employer: ____

Secondary Insurance Coverage: ____
Claims Mailing Address: ____
Insurance Company Phone: ____
Policy #: ________________________________ Group #: _______________________________________
Policy Holder's Name: ______________________ Policy Holder Date of Birth: _____________________
Policy Holder's SSN#: ______________________ Relationship to Patient: _________________________
Policy Holder's Employer: ____

AUTHORIZATION: I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government health benefits either to myself or to my physician who accepts assignment. I authorize payment of medical benefits to Southwest Pulmonary & Sleep Disroders for services provided. I understand that I am financially responsible for all charges whether paid or not by my insurance company.

Patient (or Authorized) Signature: ________________________________ **Date:** __________________

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History Intake

Who is your Primary Care Physician? ____

What is the purpose of your visit today? ____

Social History

Occupation: ________________________ Marital status: Single Married Divorced Widowed

How many children do you have and how old are they? ____

Do you consume alcohol? Yes No If yes, write type and amount per week: ____________________

Do you smoke? Yes No If yes, write type and amount per day: _____________________

Do you chew tobacco? Yes No Do you ever smoke marijuana (pot)? Yes No

Do you exercise? Yes No If yes, write type and frequency: __________________________

Past Medical and Family History

Have you or has any family member experienced any of the following? Please **check or place a X** in the appropriate box:

	Self	**Mother**	**Father**	**Sister**	**Brother**	**Spouse**	**Child**
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Other							
Age at Death							

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Medications

Please list "**ALL MEDICATIONS" (prescription, over-the-counter, herbals, and vitamins)** you take. This includes medications taken daily and medications taken only when you need them.

Name of Medicine	Strength	How You Take Your Medicine
Example: Coreg	*12.5 mg*	*One tablet twice a day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies to Medications: Please list each allergy and the reaction you had to that medicine.

1) ____________________ 2) ____________________

3) ____________________ 4) ____________________

Review of Systems

Do you have now or have you had in the past (please mark either yes or no):

Weight change	yes	no	**Chronic cough**	yes	no	**Anesthesia problems**	yes	no
Swollen feet/ankles	yes	no	**Chronic diarrhea**	yes	no	**Depression / Anxiety**	yes	no
Seizures	yes	no	**Swollen lymph nodes**	yes	no	**Rapid heartbeat**	yes	no
Dry eyes	yes	no	**Chest pain**	yes	no	**Joint / Muscle pain**	yes	no
Skin rash	yes	no	**Jaundice**	yes	no	**Easy bleeding/bruising**	yes	no
Neck pain	yes	no	**Back pain**	yes	no	**Joint problems**	yes	no

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Major Hospitalizations

If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

Year	Operation or Illness	Name of Hospital	City and State

Sleep Questions

On weekdays, I usually go to sleep at _______________ and wake at __________.
On weekends, I usually go to sleep at _______________ and wake at
__________. On average it takes me ______ minutes to fall asleep.
I need ____ hours of sleep to feel rested in the morning.

Do you snore or have you been told that you snore?	Yes	No
Do you feel sleepy during the daytime?	Yes	No
Do you have asthma?	Yes	No
Do you have high blood pressure or take medicine for that reason?	Yes	No
Do you have / get swelling in your legs?	Yes	No
Have you ever been told that you have congestive heart failure?	Yes	No
Have you ever had heart problems or heart disease?	Yes	No
Have you ever had a stroke or “warning stroke”?	Yes	No
Do you feel like your sleep is “restful” such that you feel restored in the morning?	Yes	No

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Please **check or place a X** in the appropriate box:

	Never	Rarely	Occasionally	Frequently
Have you ever been told you stop breathing in your sleep?				
Does chest pain or shortness of breath disturb your sleep?				
How often do you wake up choking or gasping for air?				
How often do you wake up with headaches?				
How often do you wake up with acid heartburn or a sour taste?				
How often does leg restlessness keep you awake?				
How often do your legs twitch or kick while you sleep?				
How often do you feel paralyzed upon waking from sleep?				
How often do you have vivid dreams in naps?				
How often do your knees feel weak or wobbly if you laugh?				
Do you get weak muscles when you get angry or surprised?				
Do you take sleeping pills or alcohol in order to sleep?				

What is your weight now? ________ lbs. 1 year ago? ________ lbs. 5 years ago? ________ lbs.

What is your height? _______ ft. ________ in.

What is your shirt collar size? ________ in.

What size pants do you wear (waist)? ________ in.

How many caffeinated beverages do you drink each day? ____________________

What time do you usually eat your last meal of the day? ______________________

Napping and Drowsiness

How many purposeful naps do you take a day? _______________ During an average week? ____________

How often do you accidentally doze off during an average day? ____________ week?__________________

Do you have difficulty focusing or concentrating in the daytime? yes no

How many times do you usually get up to urinate during the night? ___________________________________

In the last 3 years, have you caused an accident by falling asleep when driving? yes no

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Drowsiness Rating Scale

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 have affected you.

	Rating
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g., a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
EDSS Total	

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

I verify that the above information is true and accurate to the best of my knowledge.

Signature of patient (or parent if patient is a minor) **Date**

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Informed Consent for Telemedicine Consultation

Telemedicine permits two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. Telemedicine has a number of potential benefits including:

- Improved access to medical care by enabling a patient to remain close to home, while having access to specialists that may not otherwise be geographically feasible.
- More efficient medical evaluation and management.
- Improve access to timely care.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and/or recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee. I understand that unless I am notified otherwise, telemedicine interactions will not be recorded.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternatives to my satisfaction.

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Informed Consent for Telemedicine Consultation (Continued)

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

7. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

8. I understand that it is my duty to inform my neurologist of electronic interactions regarding my care that I may have with other healthcare providers.

9. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

10. I understand that billing will occur from this telemedicine consultation and that I am responsible for this in the same manner as I would be at as per the standard consultation at Southwest Pulmonary & Sleep Disorders.

My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

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Informed Consent for Telemedicine Consultation (Continued)

Patient Consent To The Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Mauricio A. Reinoso, MD to use telemedicine in the course of my diagnosis and treatment.

____
Patient's/parent/guardian signature

____
Date

____
Witness signature

____
Date

I have been offered a copy of this consent form (patient's initials) ________

Mauricio A. Reinoso, MD

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Authorization of release of medical information

Clients Name:_____________________________Date of Birth:_______

Requesting Entity:

Mauricio A. Reinoso, MD

16605 Southwest Frwy, #310 Sugar Land, TX 77479

P: 281-980-1330 / F: 281-980-1331

Releasing Entity:

Alaska Sleep Clinic

206 W. Rockwell STE 101, Soldotna AK 99669

P: 907-420-0540/ F: 907-420-0541

_________ (intial) I authorize this release to be reciprocal between two parties

Information Authorized For Release

___*Psychological Evaluations/Reports*

___*Psychiatric Evaluations/Reports*

___*Physical/Medical Records/Med. List*

___*Lab Results* ____*Sleep Study Reports*

___*Radiology Reports*

___*Emergency Reports*

___*Social History*

___*Vocational Work Info.*

___*Discharge Summary(ies)*

___*Verbal Information*

___*Information regarding HIV status*

___*Information regarding Chemical use*

I hereby authorize the above information to be released to the party I have indicated for the purpose of: continuity of care: ____other:___________________. I retain the right to revoke this authorization in writing prior to the expiration date below.

Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by HIPPA Privacy Rule.

______________________________________ ______________________________

Signature of Client or Client's Designee *Designee Relationship to Client*

______________________________________ _____________*TO*_____________

Witness *Date Authorized* *Date Ends*