DAYTON RESPIRATORY CENTER PATIENT DEMOGRAPHIC FORM

Patients Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Sex: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Do you smoke?: _____

Race: _____ Languages Spoken: _____

Marital Status: _____ Spouse's Name: _____

Referring Physician: _____ Family Physician: _____

In case of emergency please notify (relative not living with you):

Name: _____ Telephone Number: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

INS. ID#: _____ Group #: _____

Policy Holders Name: _____ Policy Holder's DOB: _____

SECONDARY INSURANCE: _____

INS. ID#: _____ Group #: _____

Policy Holders Name: _____ Policy Holder's DOB: _____

TERTIARY INSURANCE: _____

INS. ID#: _____ Group #: _____

Policy Holders Name: _____ Policy Holder's DOB: _____

AUTHORIZATION

I hereby authorize payment (If any) directly to the physician or organization providing the medical services, otherwise payable to me under terms of my insurance. I understand that I am responsible to notify Dayton Respiratory Center, Sleep Diagnostics, and/or Sleep Specialists of any changes to my insurance and/or of its termination, and supply them with all information necessary to get all claims paid. I hereby accept full financial responsibility and guarantee payment of all charges incurred for this account.

I hereby authorize Dayton Respiratory Center, Sleep Diagnostics, and/or Sleep Specialists to release any information acquired in the course of my testing.

I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to Dayton Respiratory Center, Sleep Diagnostics, and/or Sleep Specialists.

I hereby authorize photocopies of this form to be valid as the original.

Patient Signature: _____ Date: _____

PATIENT NAME: _____ ALLERGIES: _____

DATE OF BIRTH: _____ HEIGHT: WEIGHT:

DIAGNOSED PROBLEMS (Check all that apply)	SELF	PARENTS	SIBILINGS	WHEN DIAGNOSED?/COMMENTS
COPD	D	D	D	
ASTHMA	D	D	D	
HIGH BLOOD PRESSURE	D	D	D	
PNEUMONIA	D	D	D	
TUBERCULOSIS	D	D	D	
BLOOD CLOTS	D	D	D	
LUNG NODULES	D	D	D	
PULMONARY HYPERTENSION	D	D	D	
PULMONARY EMBOLISM	D	D	D	
LUNG CANCER	D	D	D	
OTHER LUNG PROBLEMS (Please explain):	D	D	D	
HEART ATTACK	D	D	D	
CONGESTIVE HEART FAILURE	D	D	D	
CORONARY ARTERY DISEASE	D	D	D	
AFIB OR OTHER ARRHYTHMIA	D	D	D	
OTHER HEART PROBLEMS (Please explain):	D	D	D	
STROKE OR TIA	D	D	D	
THYROID PROBLEMS	D	D	D	
CANCER	D	D	D	
DIABETES	D	D	D	
NEUROLOGICAL PROBLEMS	D	D	D	
NEUROMUSCULAR PROBLEMS	D	D	D	
SEIZURES	D	D	D	
OTHER ILLNESS/DISABILITY (Please explain)	D	D	D	
ARE YOU ON OXYGEN?	D	D	D	
ARE YOU ON CPAP/BIPAP/ASV?	D	D	D	
ARE YOU A SMOKER/FORMER SMOKER?	D	D	D	
ARE YOU FULLY IMMUNIZED?	D	D	D	
HAVE YOU HAD ABNORMAL XRAYS/CT'S?	D	D	D	

COMPLAINTS (CHECK ALL THAT APPLY)	
COUGH	
SORE THROAT	
ALLERGIES	
SHORTNESS OF BREATH	
WHEEZING	
CHEST PAIN	
OUT OF BREATH WHEN WALKING	
DAYTIME SLEEPINESS	
SNORING	
STOP BREATHING WHILE SLEEPING	
AWAKENING GASPING/CHOKING	
FREQUENTY NAPPING	
SLEEP WALKING/TALKING	
AWAKENING AT NIGHT	
LEGS JERK WHILE SLEEPING	
BEEN DIAGNOSED WITH NARCOLEPSY	
I TAKE SLEEPING MEDICATIONS	
I HAVE HAD SLEEP STUDIES IN THE PAST	
___I understand that it is my responsibility to obtain my original sleep studies before my doctor's office can order me a new machine, and/or supplies for my machine.	

EPWORTH SLEEPINESS SCALE

WHAT IS THE LIKELIHOOD OF YOU FALLING ASLEEP IN THE SITUATIONS LISTED BELOW? (CHECK A NUMBER FOR EACH SECTION)

(0 – no chance 1 – slight chance 2 – moderate chance 3 – high chance

Sitting and Reading	D 0 D 1 D 2 D 3
Watching TV	D 0 D 1 D 2 D 3
Sitting inactive in a public place	D 0 D 1 D 2 D 3
Being a passenger in a motor vehicle for an hour or more	D 0 D 1 D 2 D 3
Lying down to rest in the afternoon	D 0 D 1 D 2 D 3
Sitting and talking with someone	D 0 D 1 D 2 D 3
Sitting quietly after lunch (no alcohol)	D 0 D 1 D 2 D 3
Stopped for a few minutes in traffic while driving	D 0 D 1 D 2 D 3
TOTAL SLEEPINESS SCORE:	

What DME company do you use for your oxygen or pap equipment?

MEDICATIONS:

WHEN? WHERE?

DAYTON RESPIRATORY CENTER

INFORMATION CONSENT

1. Please list the family members, doctors, or other persons with whom we may discuss your general medical condition and your diagnosis:

NAME	PHONE NUMBER

I UNDERSTAND THAT THE PERSONS LISTED ABOVE ARE ABLE TO CALL AND ASK, OR REQUEST MY HEALTH INFORMATION ON MY BELHALF, AND IF I WANT TO REMOVE ANYONE OR ADD ANYONE IT MUST BE DONE IN WRITING WITH THIS OFFICE

INITIALS_____DATE_____

2. May confidential messages, i.e., request for you to contact our office, replies to your questions, normal test results, etc., be left on your home answering machine (if you have one), or with another person?

   ☐ Yes ☐ No _____

3. Please print the telephone numbers where we may call and/or leave messages about your appointments, lab tests, x-ray results, or other healthcare information in addition to your home phone number.

   _____

4. Should we need to contact you during the workday, may we call and/or leave a message for you to call us at your place of employment?

   ☐ Yes ☐ No Work Phone _____

THIS CONSENT SHALL REMAIN IN EFFECT UNTIL REVOKED OR AMENDED BY ME IN WRITING

NAME _____ DATE OF BIRTH _____

SIGNATURE _____

WITNESS _____ TODAY'S DATE _____

DAYTON RESPIRATORY CENTER

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Dayton Respiratory Center's Notice of Privacy Policies, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and that I may request restrictions concerning the use of my personal medical information.

_____ _____

Signature Date

If not signed by the patient, please indicate relationship of signer to patient (e.g., spouse, parent, etc.)

_____

Relationship

If the patient or patient's representative refuses to sign this acknowledgement of receipt of notice, please document date and time the notice was presented to the patient and sign below.

Presented on (Date/Time) _____

By (Name/Title): _____

No Show Policy-

I understand that the office has a no-show policy that states if any patient no shows 3 or more appointments in a 12-month time frame will be subject to being discharged from the practice. We appreciate at least a 24-hour notice for all cancellations, and three or more same day cancelations in a 12-month time frame will also be subject to dismissal of our practice. You will receive a phone call and certified letter stating this information, and we will provide you with 30 days of emergency medication and or inhalers. This is at the discretion of the overseeing provider.

Late policy-

Any patient that arrives 15 or more minutes late to their appointment will be rescheduled. Medical assistants are instructed to ask the provider on a case-by-case basis, but if you are more that 15 minutes late past your scheduled time our providers have the right to request you reschedule at a later date and time.

By signing below, I have read and agree to abide by the policies above as a current patient of Dayton Respiratory Center.

Patient Signature _____ Date _____