

_					
D	0	rs	0	n	2
	C	13	U		a

PLEASE MAIL
OR FAX AS
SOON AS
POSSIBLE TO
AN ADDRESS
BELOW

SANTA CLARITA Tel:661-799-1428 Fax:661-799-0968 25050 Peachland Suite 125 Santa Clarita, CA

91321

Patient Name:	Date:
Address:	
	Weight:
Gender:Home Phone:()	Cell Phone:()
Work Phone:()Email:	
Social Security #Re	eferring Physician
Chief Complaint	Please Explain:
Trouble falling asleep	
Sleepy all day	
Unwanted behaviors while sleeping	
Other	
	Yes No
***Do you need extra assistance (use of	
***Are you currently on Oxygen day/ nig	Int
Please give details of your personal h	nabits:
Tobacco	
Alcohol	
Caffeine	
Medication:	

Name of Drug	Dosage	Doses per day	Reason
Allergies	Please give	details, describe yo	ur reaction

NYX, L.L.C. • SOLUTIONS FOR SLEEP



Previous Sleep Study? (o	date) current settings
Surgeries / Operations	Please give details, date
Other Medical Problems	Please give details, date
Family History	Does anyone in your family have a sleep disorder, List significant family illnesses, give details

EPWORTH SLEEPINESS SCALE

Referring to your usual way of life, how likely are you to doze off or fall asleep during the following situations? Or refer to a specific time when the following does apply!				
0=No Chance, 1=Slight Chance, 2=Moderate Chance, 3=High Chance	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, 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 allow it				
Sitting down and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped in traffic for a few minutes				

Total Score:



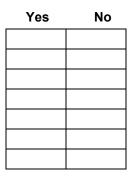
Sleep Questionnaire

Sleep – Wake Schedule:

Bedtime?	
Awakening time?	
Alarm clock?	
Do you wake up during the night? (yes,no)	
How many times?	
For how long?	
How long does it take you to fall asleep?	

Disturbed Sleep:

Do you snore?
Have you lost your bed partner because of this?
Have breathing pauses been observed?
Have you been told your limbs kick or twitch?
Talk in your sleep?
Walk in your sleep?
Act out vivid or violent dreams?



Insomnia:

Do you have trouble falling asleep?
How long does it take you?
How many nights per week?

If you wake up during the night, do you

Have trouble going back to sleep?

How long does it take you?

How many nights per week?

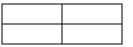
Do you have an aching, uncomfortable or squirmy sensation in your legs, which keep you from sleeping?

Are you a light sleeper, easily awakened?

Past Sleep History:

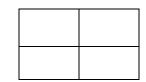
Did your current sleep problem begin in childhood?

Were you considered hyperactive or hyper kinetic as a child or teenager (Attention Deficit Disorder)?



No

Yes



Yes No

NYX, L.L.C. • SOLUTIONS FOR SLEEP

NYX Sleep Disorders Center Solutions For Sleep

ADULT HISTORY

Sleep Questionnaire - continued

Daytime Sleepiness:

Are you sleepy or tired all day?

Have you had accidents or near accidents because of sleepiness?

Have you "come to" or suddenly become alert and found yourself doing things without being aware of having started them remembering how you got there?

Have you experienced sudden weakness in the legs or body in general, while awake, perhaps after being startled or in an emotional situation?

Have you had hallucinations or dream like images

While awake?

While falling asleep?

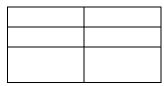
Do you take naps during the day?

How many days per week?

- How long are the naps?
- Are they refreshing?
- Do you dream during your naps?

Did you fall asleep, or fight the urge to fall asleep in school as a child or adolescent?

Yes No



Spouse, Roomate or Bed Partner Questionnaire:

(to be filled out about you by your spokee, led ant at your spoker on the spoke of			
paotmen)e / she stop breathing?			
Does his / her legs or body twitch or kick?			
Does he / she grind his / her teeth?			
Does he / she walk in his / her sleep?			

Does he / she sit up in bed while not awake?

Does he / she become rigid or shake during sleep?

Occ Never	asionally Occasionally	Frequently Frequently



Insurance Information

PRIMARY INSURANCE:

Company Name:			
Mailing Address:		Zip Code:	
City/State:		Relationship to Patient:	
Name of Subscriber:	Subscriber's DOB:		
Policy Number:	Group #	-	
ID Number:		Effective Date:	

SECONDARY INSURANCE COMPANY:

Company Name:		
Mailing Address:	Zip Code:	
City/State:	Relationship to Patient:	
Name of	Subscriber's DOB	
Policy Number:	Group #:	
ID Number:	Effective Date:	

Payment Policy: Payment is due <u>at the time</u> services are rendered unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. Our Policy allows a maximum of 90 days for insurance companies to pay claims. If this does not occur, you will be expected to pay the balance to NYX.

Patient Authorization: I hereby authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize Palmetto GBA to release information regarding Medicare claims submitted by the named provider.

This office requires a 48-hour advance notice of cancellation when a sleep study has been scheduled. If not given, NYX reserves the right to charge a \$175 nonrefundable fee to the person responsible for the patient listed above and/or decide if the patient will be re-scheduled for a later date.

SIGNED:

DATE:

(Patient or Guardian if Minor)

NYX, L.L.C. • SOLUTIONS FOR SLEEP