UB|MD SLEEP MEDICINE HISTORY FORM

NAME:_____ DOB:_____ SEX: M/F

WEIGHT:_____ HEIGHT:_____

PHARMACY:_____

PRIMARY CARE PROVIDER:_____

EMAIL ADDRESS:_____

PLEASE CIRCLE THE APPROPRIATE RESPONSE

SLEEP ROUTINE:

1. What time do you go to bed? _____
2. How long does it take for you to fall asleep? _____
3. Do you frequently wake up in the middle of the night? _____
   - A. If yes, how many times? _____
   - B. What is the reason for waking in the night? _____
   - C. How long does it take to fall back asleep? _____
4. What time do you wake up in the morning? _____
5. Do you feel refreshed upon waking up? YES/NO
6. Do you take any
   - A. Scheduled/planned naps? YES/NO
   - B. Unscheduled/Unplanned naps? YES/NO
   - C. If yes, do you feel refreshed after nap? YES/NO
7. Any change in sleep schedule on your days off? YES/NO
8. Have you recently had any change in your weight In the past 3 years? GAINED/LOST How much? _____

SLEEP APNEA SYMPTOMS:

9. Has anyone told you that you snore? YES/NO
   - A. If yes, how loud? MILD/MODERATE/SEVERE
10. Has anyone seen you stop breathing? YES/NO
11. Do you have pauses in breathing when you sleep? YES/NO
12. Do you wake up from sleep with a Choking/Gagging sensation? YES/NO
13. Has anyone told you that you make Snorting/Gasping noises in your sleep? YES/NO
14. Do you wake up with a dry mouth? YES/NO
15. Do you wake up with a headache? YES/NO
16. Do you drool on your pillow? YES/NO
17. Do you feel tired during the day? NO/MILD/MODERATE/SEVERE

Have you ever had a sleep study before? YES/NO

UB|MD SLEEP MEDICINE HISTORY FORM

RESTLESS LEGS:

1. Do you have uncomfortable sensations In your legs before bedtime? YES/NO
   A. If yes, describe them _____

2. Do you have any of the following during sleep?
   A. Sleepwalking YES/NO
   B. Sleep Talking YES/NO
   C. Night Terrors YES/NO
   D. Nightmares YES/NO
   E. Acting out dreams YES/NO

SLEEP HYGENE:

1. Do you do any of these activities in your bed/bedroom?
   A. Watch Tv YES/NO
   B. Eat YES/NO
   C. Read YES/NO
2. Do you drink coffee or caffeinated beverages? NEVER/OCCASIONAL/MODERATE
3. SMOKING NEVER/FORMER/CURRENT
4. ALCOHOL NEVER/OCCASIONAL/MODERATE
5. DROWSY DRIVING NEVER/OCCASIONAL/FREQUENTLY

MISCELLANEOUS:

1. When falling asleep or waking up
   A. Do you ever see or hear things? YES/NO
      If yes, Describe _____
   B. Do you ever feel paralyzed? YES/NO
2. Do you ever feel sudden muscle weakness when laughing? YES/NO

FAMILY HISTORY:

1. Does anyone in your family have sleep apnea? YES/NO
   A. If yes, who? _____

UB|MD SLEEP MEDICINE HISTORY FORM

DRUG ALLERGIES: Check box if no known drug allergies □

1. Drug name _____ Reaction _____
2. Drug name _____ Reaction _____
3. Drug name_____Reaction_____

CURRENT MEDICATIONS: Please list all of your medications strength and dose

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY: Check the symptoms you frequently experience:

□Hypertension	□Congestive heart failure	□Thyroid disease
□Heart attack	□Stroke/TIA	□Diabetes
□Cardiac arrhythmias	□Pulmonary hypertension	□Heartburn/reflux
□Asthma or COPD	□Anemia/iron deficiency	□Fibromyalgia
□Parkinson's disease	□Sexual dysfunction/loss of libido	□Menopause
□Arthritis	□Seizures	□Cancer
□Depression/Anxiety	□Connective tissue disease (Lupus)	□Broken nose
□Nasal allergies/congestion	□End stage kidney disease/dialysis	□Head injury

Other: _____

SURGICAL HISTORY: Please list previous surgeries

_____

_____

REVIEW OF SYSTEMS:

Const: □Fever □ Feeling poorly □ Feeling tired

ENT: □Ear pain □Frequent nosebleeds □ Sore throat □Hearing loss □Nasal discharge □Hoarseness lasting more than 2 weeks

Heart: □Passing out □Chest pain, Tightness or Pressure □Irregular heartbeat □Palpitations □Swelling in feet or ankles

Resp: □Shortness of breath □Frequent cough for more than 2 weeks □coughing up blood □wheezing

GI: □Abdominal pain □Difficulty swallowing/ food "sticking" □Frequent heartburn/indigestion □Constipation □Diarrhea □Blood in stool/Black stool

MSK: □Joint pain □Joint swelling □Joint stiffness □Limp pain □Limb swelling □Muscle pain

Neuro: □Frequent headaches □Seizures □Sudden loss of vision or strength □Inability to speak □Ringing in ears

Behav: □Anxiety □Change in personality □Sleep disturbance □Depression □Emotional problems

Hema: □Swollen glands □Easy bleeding □Easy bruising

GU: □Nocturia □Urinary Frequency □ Urinary urgency

UB|MD
INTERNAL MEDICINE

1020 Youngs Rd.
Williamsville, NY 14221
P: 716.961.9900
F: 716.961.9911

1001 Main Street
Buffalo, NY 14203
P: 716.961.9900
F: 716.961.9911

6105 Transit Rd.
E. Amherst, NY 14051
P: 716.348.3435
F: 716.204.8229

300 Linwood Ave.
Buffalo, NY 14209
P: 716.961.9400
F: 716.961.9402

6400 Edgewood Dr.
Niagara Falls, NY 14304
P: 716.898.4803
F: 716.898.3928

462 Grider St.
Buffalo, NY 14215
Nephrology
P: 716.898.4803
F: 716.898.3928
Behavioral Med:
P: 716.898.5671

UBMD Internal Medicine Patient Agreement

Thank you for choosing UBMD Internal Medicine as your healthcare provider. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, below is some introductory information and our financial policy.

General Information
Billing Office: 716.816.7200
Hours: Monday - Friday 7:30 am – 4:30 pm
Patient Website: ubmdim.com

If you wish to contact a physician regarding a medical matter, please call the appropriate office above or use the Patient Portal (see information on page 2). **DO NOT contact physicians via University or buffalo.edu email**, as they are not HIPAA-compliant and do not offer protection for health information. A medical provider is on call seven (7) days a week to take urgent calls outside normal business hours. Your call will be returned within one (1) hour. **For emergencies, call 911.**

Our phone message is updated as needed to report any weather-related closings.

Appointments
Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur) and aim for patients to be in the exam room at their appointment time. You will receive an automated pre-appointment reminder call two (2) to five (5) business days before your appointment. It is important for you to notify our office if your phone number has changed. Please specify if you prefer your home or mobile number as your primary contact.

Prescription Refills.
For routine refills, please contact your pharmacy and have them send a prescription refill request electronically. Refills can be requested through our Patient Portal for those who are currently enrolled. Please allow five (5) business days to have all medications refilled. For refill requests needed in less than five (5) business days, contact the office.

Form Completion Fee
There will be a $10 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of request. Please allow seven (7) business days for us to complete any forms.

Test Results
Please allow seven (7) business days for laboratory results or other diagnostic test results unless instructed by your physician. Your physician will review all test results and contact you if follow up is needed. Routine lab results may be relayed by postal mail, patient portal or telephone.

Address and/or Phone Number Change
Please advise our practice anytime there is a change in your address, phone number, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

Financial Policy
Your clear understanding of our Patient Financial Policy (available on our Patient Resources web page, or by request at the office) is important to us. Please ask if you have any questions about our fees, policies, or your responsibilities.

Insurance Verification and Copayments
Patients are expected to present valid photo identification and their insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing supervisor. Failure to pay your copay at the time of service will result in an additional $10 fee. We accept cash, check, credit card or flexible spending card. No post-dated checks are accepted. A $35 returned check fee is added to any insufficient funds amount owed by the patient. The patient may be placed on a cash-only basis following any returned check.

Insurance Claims
The practice will bill the patient's primary insurance company. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance, as well as any insurance changes. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although the practice may estimate the amount the insurance company may pay, it is the insurance company that makes the final determination of the patient's eligibility and/or benefits. The patient is responsible and agrees to pay for any non-covered services provided. If the insurance company is not contracted with the practice, the patient agrees to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

Participating Insurances
The practice accepts most insurance plans including but not limited to: Blue Cross/Blue Shield, Empire, Fidelis, Independent Health, Univera, United Healthcare, Wellcare, and Medicare. Participation in insurance plans may change. It is your responsibility to verify if UBMD Internal Medicine participates in your plan. If your physician does not participate with your insurance, you have the right to request an estimate of cost.

UBMD Internal Medicine

Assignment of Benefits, Financial Responsibility, Release of Information And Receipt of Notice of Privacy Practices

- **Assignment of Benefits**
  I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to UBMD Internal Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
  Please initial x_____

- **Financial Responsibility**
  I have requested medical services from UBMD Internal Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I also acknowledge that I have read the financial policy of the practice, agree to be bound by its terms and understand that such terms may be amended from time-to-time by the practice.
  Please initial x_____

- **Release of Information**
  I authorize the release of necessary medical information to UBMD Internal Medicine for the purpose of processing this or any related claim. I also authorize UBMD Internal Medicine to release requested documentation of this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition.
  Please initial x_____

- **Teaching Facility**
  I acknowledge that UBMD Internal Medicine is affiliated with the University at Buffalo School of Medicine and Biomedical Sciences and as such students may become involved in my care. If you are concerned about the involvement of medical students, please speak to the physician responsible for your care.
  Please initial x_____

- **Phone Notifications**
  I authorize UBMD Internal Medicine to remind me of my appointments and other useful information using automatic, prerecorded or artificial voice calls to me on the phone number I listed; even if it is a cellular phone number
  Please initial x_____

- **Notice of Privacy Practices**
  We are required to provide you a copy of our Notice of Privacy Practices which describes how medical information about you may be used and disclosed and how you can get access to this information. Any restrictions concerning the use of your personal medical information must be made in writing. By signing below, I acknowledge that I received a copy of UBMD Internal Medicine's Notice of Privacy Practices.
  Please initial x_____

Documentation of Good Faith Efforts – For UBMD Internal Medicine use only

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of UBMD Internal Medicine's Notice of Privacy Practices. However, such acknowledgment was not obtained because:

_____ Patient refused to sign
_____ Due to an emergency, it was not possible to obtain an acknowledgement
_____ Unable to communicate with patient
_____ Other (please provide specific details)

_____

_____

_____ _____
Employee Signature Date

_____ _____
Patient Name (print) Patient Date of Birth

_____ _____
Patient Signature or Responsible Party if a Minor Date

HEALTHeLINK Authorization for Access to Patient Information Through HEALTHeLINK

Patient First Name

Patient Last Name

Date of Birth M M / D D / Y Y Y Y

Patient Address

Street _____ Apartment _____

City _____, State _____ Postal Code _____

Gender

☐ Male

☐ Female

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at www.wnyhealthelink.com.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

SELECT ONLY ONE

My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☐ **1. YES**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **4. NO, EXCEPT IN AN EMERGENCY**	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐ **5. NO, EVEN IN AN EMERGENCY**	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative

X_____

Date of Signature M M / D D / Y Y Y Y

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other_____

This Box To Be Filled Out Only By The Provider

UBMD INTERNAL MEDICINE AND PEDIATRICS

Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

Print Name of Witness _____ Signature of Witness _____

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

UB|MD INTERNAL MEDICINE

HIPAA CONTACT AND AUTHORIZATION FOR RELEASE

1001 MAIN STREET
BUFFALO, NY 14203
P: (716) 961-9900
F: (716) 961-9911

1020 YOUNGS RD.
WILLIAMSVILLE, NY 14221
P: (716) 961-9900
F: (716) 961-9911

6105 TRANSIT RD.
E. AMHERST, NY 14051
P: (716) 348-3435
F: (716) 204-8229

300 LINWOOD AVE.
BUFFALO, NY 14209
P: (716) 961-9400
F: (716) 961-9402

6400 EDGEWOOD DR.
NIAGARA FALLS, NY 14304
P: (716) 898-4803
F: (716) 898-3928

462 GRIDER ST.
BUFFALO, NY 14215
NEPHROLOGY
P: (716) 898-4803
F: (716) 898-3928
BEHAVIORAL MED:
P: (716) 898-5671

Patient Name:	Date of Birth: / /

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the UBMD Internal Medicine, Inc. Notice of Privacy Practice. (also available at UBMDIM.COM)

Signature:	Date: / /

☐ Patient refused and/or unable to sign
Staff member signature:

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY AND/OR FRIENDS

Name	Relationship	Primary Phone	Secondary Phone

AUTHORIZATION TO LEAVE MESSAGES

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you:

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
Voice Mail on Alternate Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
		May we send a message?	
Send through US Mail		☐ Yes ☐ No	

RESTRICTIONS TO RELEASE OF INFORMATION

Please list any restrictions regarding information to be released:

SIGNATURE

Signature:	Date: / /

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

EPWORTH SLEEPINESS SCALE FORM

NAME_____DOB_____DATE_____

*The test is a list of eight situations in which you rate your tendency to become Sleepy

Instructions: Be truthful, Write down the number corresponding to your choice in the right hand column and Total your score below.

No chance of dozing =0
Slight chance of dozing =1
Moderate chance of dozing =2
High chance of dozing =3

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a 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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score = _____