ADVANCED SLEEP TREATMENT

10230 New Hampshire Ave., Suite 330
Silver Spring, MD 20903
Tel: 301-439-8333
Fax: 301-439-4622

NEW PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ MI: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Best time to call: Mom/Noon/Night Call: Home/Cell/Work Email: _____
DOB: ____/____/_____ SS#: _____ Height: _____ Weight: _____
Address: _____ City: _____State: _____ Zip: _____
Marital Status: S/M/D/W Referred by: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
EMPLOYER INFORMATION:
Employer: _____ Phone: _____

INSURANCE INFORMATION:
Insurance Company Name: _____ Phone: _____
Group Policy/TWCC #: _____ Group Name: _____ Insurance ID#: _____
Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company
FIRST NAME: _____ LAST NAME: _____ MI: _____
DOB: ____/____/_____ Cell Phone: _____ Email: _____
Employed by: _____

SECONDARY INSURANCE INFORMATION: Insurance Company Name:
Insurance Company Name: _____ Phone: _____
Group Policy/TWCC #: _____ Group Name: _____ Insurance ID#: _____
Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company
IF other than self, please provide the insured person DOB: _____/_____/_____

MEDICAL CONTACTS:
Advanced Sleep Treatment coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers:
PRIMARY CARE DOCTOR: _____ PHONE: _____
ENT: _____ PHONE: _____
SLEEP DOCTOR: _____ PHONE: _____
DENTIST: _____ PHONE: _____

I CERTIFY THIS INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

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MEDICAL HISTORY

It is important that we know your medical history. Many things have a direct bearing on your sleep health. Information you give us is strictly confidential and will not be released to anyone without your permission.

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? PLEASE CHECK YOUR ANSWER

	YES	NO		YES	NO
High Blood Pressure / Hypertension			Anemia		
Low Blood Pressure			Jaundice / Liver Disease		
Heart Murmur			Bleeding Disorder / Hemophilia		
Rheumatic Fever			Kidney Disease		
Mitral Valve Prolapse (MVP)			Organ Transplant		
Angina Pectoris / Chest Pain			Cancer (Type)		
Heart Attack			Chemotherapy		
Prosthetic (artificial) Heart Valve			Radiation Therapy		
Irregular / rapid heart beat			Epilepsy / Seizure		
Pacemaker / Implanted defibrillator			Stomach Ulcer		
Heart Disease			Colitis / Intestinal Problems		
Heart or Bypass Surgery			Osteoarthritis		
Malnourishment			Rheumatoid Arthritis / Lupus		
Stroke			Artificial Joints / Screws		
Emphysema			Sexually Transmitted Disease (STD)		
Asthma			AIDS / HIV		
Diabetes (Type)			Tuberculosis (TB)		
Thyroid Disease / Goiter			Psychiatric Treatment		
Liver Disease			Alcohol / Substance Abuse		
Hepatitis (Type)			Allergy to Latex		
Blood Transfusion			Pregnant / Nursing		
Renal Dialysis			Other (specify)		

PLEASE LIST ALL MEDICATIONS, INCLUDING VITAMINS AND OVER THE COUNTER MEDICATIONS:
i.e., aspirin, vitamins, herbs, etc.: _____

Do you drink Coffee or Tea? _____ How many cups in a day? _____ Do you use Tobacco? _____

Allergies: _____
Hospitalizations: _____ Surgeries: _____

Other Medical Concerns? _____

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

ADVANCED SLEEP TREATMENT COORDINATES TREATMENT WITH YOUR HEALTHCARE PROVIDERS TO HELP ENSURE MAXIMUM BENEFIT TO YOU. PLEASE SIGN THE RECORD RELEASE FORM BELOW SO WE CAN RETRIEVE RELATED MEDICAL RECORDS.

Patient Name: _____ Date of Birth: _____

I request and authorize _____
To release healthcare information of the patient named above to Advanced Sleep Treatment
Office: 10230 New Hampshire Ave, Suite 330
Silver Spring, MD 20903
Phone: 301-439-8333
Fax: 301-439-4622
Email: iulia@tomenkofamilydentistry.com

•All healthcare information in regard to said patient for the past year, i.e office notes, sleep reports, etc
•Any and all pertinent note about patient's past medical history. Please fax to the number listed above.

Patient/Guardian Signature: _____
Patient Name: _____
Date: _____

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Assignment of Benefits

_____ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization. I hereby assign and convey directly to the below-named health care provider ("Provider"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of its managed care network participation status.

_____ I understand that I am financially responsible to the Provider for any charges regardless of health care benefits. It is my responsibility to notify the Provider of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my health care insurer if the submitted claims or any part of them are denied for payment.

_____ I hereby authorize the Provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the Provider or its attorneys in order to claim such medical benefits.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

PROVIDER: ADVANCED SLEEP TREATMENT LLC, Dr. Ekaterina Tomenko
10230 New Hampshire Ave., Suite 330, Silver Spring, MD 20903

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient/Parent Signature: _____ Printed name: _____
Date: _____

Witness Signature: _____ Printed name: _____
Date: _____

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AFFIDAVIT FOR INTOLERANCE TO CPAP

I, _____, make this statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth true and correct to the best of my knowledge.
Dr. _____ has prescribed the nasal CPAP to manage my sleep-related breathing disorder (apnea) and it has been advised that it is the GOLD STANDARD OF CHOICE for treatment of Obstructive Sleep Apnea.
I have attempted to use a CPAP/BIPAP/APAP and find it intolerable to use on a regular basis for the following reason(s).

(PLEASE SELECT ALL THAT APPLY)

□ Mask Leaks
□ Mask and/or device uncomfortable o Unable to sleep comfortably
□ Noise from the device disturbs me and/or my bed partner's sleep
□ Restricts movement during sleep or does not seem to be effective
□ Straps/Headgear cause discomfort
□ Pressure on upper lip causes tooth-related problems or Latex Allergy
□ Claustrophobia
□ Other: _____

OR

I have NOT attempted to use a CPAP/BIPAP/APAP device and would prefer to use an oral appliance, the following reason(s). (PLEASE SELECT ALL THAT APPLY)
□ I'm worried that the mask, straps/headgear will cause discomfort.
□ I'm worried that the noise from the device will disturb me and/or my bed partner's sleep o I'm worried that the device will restrict movement during sleep
□ I have a latex allergy
□ I suffer from claustrophobia
□ I travel frequently and am worried that a CPAP/BiPAP/APAP device will be cumbersome to transport.
□ Other: _____

By signing this consent form you acknowledge that you have been made aware of reasonable alternatives to MAD therapy for obstructive sleep apnea including, but not limited to: tracheotomy; CPAP; oral or pharyngeal surgery; positional sleep therapy; weight loss and exercise. Additionally, you are aware that more than one treatment may be necessary for the best results.

Patient Signature: _____ Date: _____

Witness signature: _____ Date: _____

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General Release of Liability & Assumption of Risk for Obstructive Sleep Apnea and Sleep Disordered Breathing

I, _____ understand that due to the nature of sleep medicine that failure to comply with the treatment can result in severe physical and social issues including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; hypertension; excessive sleepiness; and increased mortality.

As this office cannot ensure success of any type of therapy and cannot guarantee that any patient will comply with the treatment for sleep apnea, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I might sustain as a result of my treatment for sleep apnea or any failure on my part to comply with treatment.

Therefore, I release this office and its affiliates from any and all liability associated with my treatment and I personally assume all risks associated with my care, including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; increased work place accidents; hypertension; excessive sleepiness; TMJ disease; periodontal disease and increased mortality.
I hereby agree to indemnify and hold this office and its affiliates harmless for any issues or damages that might result from my sleep apnea treatment.

Patient Signature: _____ Date: _____
Printed Name: _____

Witness Signature: _____ Date: _____
Printed Name: _____