Suburban Sleep
& PULMONARY MEDICINE

Dear Valued Patient,

We are delighted to have you as a new patient to our practice. This welcome packet has been designed to help us build your patient profile. Our goal is to thoughtfully guide you through the patient experience before, during, and after your scheduled appointment. Thank you for entrusting us with your care.

Before Your Appointment

- Complete the patient forms: You will need your medical history, insurance information, and credit card on hand. ALL forms need to be completed, prior to scheduling your appointment.
- Submit Welcome Packet Using one of the Following Methods:
  - EMAIL: sleepbetter@suburbansleep.com
  - FAX: 815-773-9099
  - US MAIL ***Please allow 7-10 business days for this method***
  - DROP OFF AT OUR OFFICE (Mailing address is the same)

    3077 W. Jefferson St. Suite 210

    Joliet, IL. 60435

Our Communication to You

- WAIT FOR A CALL
- One of our friendly office coordinators will call you to schedule an appointment.

What to Bring to Your Appointment

- Insurance card
- Photo identification
- Co-pays, co-insurance and any outstanding balances, are due at check-in.
- Any other specific instruction that was requested when scheduling your appointment.
- If you have had one or more **sleep studies** in the past, we must have copies of these at the time of your visit. Our staff may be able to assist you in locating them. If you cannot obtain your prior studies, please understand that you may have to repeat them in order to further your care.
- If you have a **CPAP or BiPAP device**, bring it with your mask to the appointment.

During Your Appointment

- Our clinical team will take the time to get to know you, listen to your concerns, and develop the best plan of care for you. We will assist you with coordinating and scheduling any necessary testing and follow-up appointments during the check-out process

PATIENT DEMOGRAPHICS

LAST NAME:_____ FIRST NAME: _____ MI: _____

DOB: _____ SEX: M F

STREET ADDRESS: _____ APT #_____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE: _____ (CIRCLE) CELL OR HOME

SECONDARY PHONE: _____ (CIRCLE) CELL OR HOME

HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDER (CIRCLE) EMAIL OR TEXT MESSAGE

EMAIL: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP TO PT: _____

PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ RESPONSIBLE PARTY: _____

MEMBER ID: _____ GROUP # _____

SECONDARY INSURANCE (IF APPLICABLE): _____

MEMBER ID: _____ GROUP #: _____

PHYSICIANS INFORMATION

REFERRING PROVIDER: _____ PHONE # :( ) _____

CITY: _____ STATE: _____ ZIP: _____

AVAILABILITY

MONDAY AND THURSDAY: 8:30AM – 4:00PM

WEDNESDAY: 10:00AM - 4:00PM

PREFERRED APPOINTMENT DAY (CIRCLE) M W Th PREFERRED APPOINTMENT TIME _____

***PLEASE NOTE**: IF YOU NEED TO CANCEL YOUR APPOINTMENT, KINDLY CALL OUR OFFICE 815-773-9090, AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT. WE HAVE A $100 MISSED APPOINTMENT FEE, WHICH WILL BE CHARGED TO THE CREDIT CARD WE HAVE SECURED IN YOUR ELECTRONIC HEALTH FILE.*

GENERAL SLEEP HISTORY

Today's date _____

Last name: _____ First name: _____ MI: _____

Date of birth: _____ Height: _____ Weight: _____

Describe your sleep problem in your own words: _____

_____

_____

What time do you usually go to bed on weekdays? _____ Weekends? _____

How long does it usually take you to fall asleep? _____

What time do you usually wake up on weekdays? _____ Weekends? _____

Do you usually feel rested upon awakening in the morning? Yes No

Is your sleep often restless or disturbed? Yes No

Do you have difficulty staying asleep? Yes No

Do you suffer with daytime sleepiness or fatigue? Yes No

Do any of your blood relatives have sleep problems? If yes, please describe:

_____

_____

Has your weight changed over the past 5 years? If so, how much? _____

Do you drink alcohol? Describe when and how much: _____

Do you smoke or chew any tobacco products? How many per day? _____

Do you use any recreational drugs? Yes No

Do you have any allergies? If yes, please list:

_____

Do you have any current health problems, conditions or past surgeries?

If yes, please list:

_____

_____

Do you snore? Yes No

Do you awaken from sleep choking or gasping for air? Yes No

Has anyone told you that you stop breathing during sleep? Yes No

Do you have headaches when you awaken in the morning? Yes No

Do you awaken from sleep with your heart pounding? Yes No

Do you get heartburn at night? Yes No

Do you awaken from sleep with a dry mouth or sore throat? Yes No

Do you ever become weak or fall asleep suddenly when laughing, crying, or if you are suddenly startled? Yes No

When falling asleep or awakening, do you ever hear or see things that you know are not real? Yes No

Do you ever feel paralyzed (unable to move or talk) when falling asleep or awakening? Yes No

Do you ever physically act out your dreams? Yes No

On average, how many times per night do you use the bathroom? _____

Do you ever eat or drink at night without being aware of doing do? Yes No

Do you grind or clench your teeth during sleep? Yes No

Do you sleepwalk? Yes No

Do you have episodes of bedwetting? Yes No

Do you have frequent nightmares? Yes No

Have you have had one or more **sleep studies** in the past? Yes (See Below) No

If yes: We **must** have copies of these at the time of your visit. Our staff may be able to assist you in locating them. If you cannot obtain your prior studies, please understand that you may have to repeat them in order to further your care.

Do you have a **CPAP or BiPAP device?** Yes (See below) No

Who is your Durable Medical Equipment Company / Supplier? _____

If you have a CPAP or BiPAP you **must** bring it with your mask to the appointment

EPWORTH SCORE

Given the following situations, how likely are you to fall asleep? (Use the following rating scale to choose the best answer)?

0 = Would never fall asleep
1 = Slight chance of falling asleep
2 = Moderate chance of falling asleep
3 = High chance of falling asleep

Sitting and reading? _____

Watching television? _____

Sitting inactive in a public place (i.e. 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? _____

While driving a car, stopped for a few minutes in traffic? _____

TOTAL _____

MY MEDICINE RECORD

Today's date: _____

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)
	/ /

WHAT I'M USING Rx - Brand & generic name; OTC - Name & active ingredients	DOSAGE	FREQUENCY	REASON (or medical condition)

Guarantee of Payment

Suburban Sleep and Pulmonary Medicine

Arlington Heights Office
3421 N. Arlington Heights Rd
Arlington Heights, IL 60004-1356

Joliet Office
3077 W. Jefferson Suite 210
Joliet, IL 60435-5264

I, the Credit Card Holder, understand that by signing this document I am guaranteeing payment to Suburban Sleep and Pulmonary Medicine for services provided to the patient listed below (patient may or may not be the same as cardholder). If I am not the Patient, I understand that I am not entitled to view the patient's medical record under the Hospital Insurance and Portability Act (HIPPA), unless the Patient is a minor.

I understand the patient's insurance carrier may make payments for all or part of the medical service visits, and for equipment and supplies provided to the patient. I agree that I am responsible for all deductibles and co-payments not covered by the insurance carrier, and for all charges denied by the insurance carrier. Payment is due upon receipt of statements showing balance due.

By providing this credit card number, I agree that Suburban Sleep and Pulmonary Medicine may charge my card for unpaid balances after two (2) unpaid monthly statements mailed to the patient's home address or email address on file with The Sleep Center.

I understand that this credit card will be charged a $100 fee for a missed new patient office visit, and $50 for a missed follow-up office visit, if a 24-hour notice is not given.

Checks returned for insufficient funds will result in a $35.00 charge to cover bank service fees. In addition, if the patient's unpaid account is transferred to a collection agent, a fee of 28% of the total amount due, plus any necessary attorney fees, will be added to the balance due.

I have read and understand all of the terms and conditions outlined above. **Please initial here**: _____.

Credit Card Information

Name as it appears on card: _____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Credit Card Type: _____

Number: _____

Expiration: (_____ /_____) Security Code: _____

Signature of credit card holder: _____ Date: _____
If my signature is different from name on this credit card, I have stated to the witness that I am an authorized user of this credit card.

Signature of patient (or guardian) _____ Date: _____
If cardholder is not the patient, this signature authorizes cardholder to obtain information about the nature of any and all charges.

Witness: _____ Date: _____