MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

5050 POPLAR AVENUE, SUITE 700
MEMPHIS, TN 38157
(901) 276-6507
WWW.MSPULMONARY.COM

Dear____.

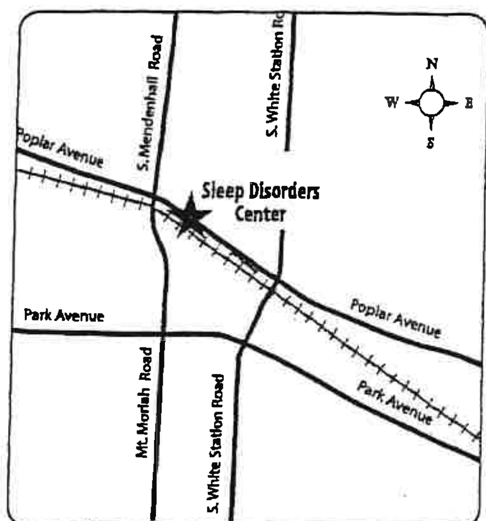
This confirms your appointment for an evaluation with our Sleep Specialists;
Dr. Robert Aguillard, Dr. James Andrews, Dr. William Mariencheck, Dr. David Williams,
Dr. Merrill Wise, Dr. Junaid Zaidi, at our Sleep Disorders Center.

Monday Tuesday Wednesday Thursday Friday ____________ at ___________ A.M./P.M.

In order to evaluate you properly we require that you accurately complete the enclosed questionnaire and forms and bring with you to your appointment. Please allow up to two hours for your appointment. On the day of your appointment, please arrive 15 minutes before your appointment time. You will need to go to the Sleep Disorders Center, which is located on the 7th floor of the I-Bank Building in East Memphis located at 5050 Poplar Ave., Suite 700, Memphis, TN 38157. Parking is located in the front and back of the I-Bank Building.

Please bring your insurance cards, all co-pay and/or deductibles, and this completed packet with you to your appointment. Also, if you have had a Sleep Study in the past, please bring a copy of the report with you. If you are currently on a CPAP machine, please bring the machine with you.

If you cannot keep your appointment, please call (901) 276-6507 between the hours of 8:00 a.m. – 4:30 p.m. to reschedule your appointment.



5050 Poplar Avenue, Suite 700
Memphis, TN 38157
(located in i-Bank Tower)

MID-SOUTH PULMONARY SPECIALISTS/SLEEP DIVISION

5050 POPLAR AVENUE, SUITE 700
MEMPHIS, TN 38157
www.mspulmonary.com

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (If Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize medical treatment by my physician. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health insurance benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing. I have received a copy of the Mid-South Pulmonary Specialists, P.C. Notice of Privacy Practices for Health Related Information.

ARE YOU HISPANIC OR LATINO--YES/NO

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: ______________________________ SS#: ______________________________

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION CONTAINED IN MY MEDICAL RECORD TO THE FOLLOWING PERSONS:

____

____

I authorize the practice to disclose or provide protected health information directly to me at the email address, fax number, phone number, cell phone number, or alternative address that I have indicated below. I am also allowing Mid-South Pulmonary Specialists to leave a message on my answering machine or with the person answering the telephone regarding appointments, etc. I understand that it is my responsibility to notify the practice of my preferred method of communications or any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, and carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

☐ **Cell phone:** ☐ **email address:** ☐ **mail:** ☐ **fax number:** ☐ **other phone:** ☐ **text message:**

____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ Office notes
- ☐ Lab results, pathology reports
- ☐ X-rays
- ☐ Financial history report (previous 3 yrs. only)
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Only send the following: ______________________________

PURPOSE OF DISCLOSURE (please state the purpose of the disclosure or check patient request):

☐ **Patient Request** ☐ **Other (please specify):** ______________________________

When requesting information to be disclosed, please specify the format in which you would like the PHI provide to you. We will accommodate your request, if possible. Please be advised that there may be costs involved in providing the PHI requested.

☐ Paper copy ☐ electronic copy via the following: ☐ CD ☐ flash drive ☐ other means: ______________________________

By signing below, I agree with the following information:

Expirations or termination of authorization – This authorization will need to be renewed every twelve (12) months, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.
Please list desired expiration date: ______________________________
Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in-person or by mailing a written request to the practice, attn.: Compliance Office.
Non-Conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.
Re-disclosure Statement: I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

I understand that authorizing disclosure of this health information is voluntary. I do not need to sign this form to assure treatment. HOWEVER, IF THIS AUTHORIZATION IS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY, MY ENROLLMENT IN THE STUDY MAY BE DENIED. Also, if this authorization is needed for the sole purpose of creating protected health information to disclose to a third party, my treatment may be denied.

I understand I am entitled to a copy of this form. I have seen and had an opportunity to read the notice of privacy practices for health related information.

______________________________ ______________________________
Signature of patient or legal representative Date

____
Relationship to patient

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
MEDICATION VERIFICATION SHEET

PATIENT NAME ______________________________ CHART/MRN# ____________________

DATE OF VISIT ______________________________ ALLERGIES: ____________________

NAME OF PHARMACY ________________________ Pharmacy Phone #____________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.
(INCLUDING INHALERS AND VITAMINS)

MEDICATION NAME	DOSAGE/STRENGH/MG	FREQUENCY (times per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL? YES___ NO___

______________________________ ____________________
SIGNATURE DATE

Rev. 10.3.19

PATIENT QUESTIONNAIRE
MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

NAME:____ **DATE:**_____/_____/_____

Referring Physician:____________________ **Primary Care Physician:** ______________________

Marital Status:____________________ **Age:**___________ **Height:**___________ **Weight:**_________

Pharmacy Name: ______________________ **Pharmacy Phone Number:** ____________________

PAST MEDICAL HISTORY (Place check ☑ Yes or No beside all conditions that apply to you. If you have other conditions, please write them down in the space provided.

Condition	YES	NO		Condition	YES	NO
Atrial Fibrillation				Heart Disease		
Asthma				Hypertension		
Cancer;				Insomnia		
Where?				Lupus		
Seizure(s)				Restless Leg Syndrome		
Congestive Heart Failure				Sleep Apnea		
COPD				Stroke		
Coronary Artery Disease				Thyroid Disorder		
On Oxygen				Floppy/Droopy Eyelids		
Neurodegenerative Disorder: MS; Parkinson's; Alzheimer's; Other:				**Neuromuscular Disorder: Muscular Dystrophy, Myasthenia Gravis, ALS, Peripheral Neuropathy; Other:**		
Diabetes				Depression		
Dysrhythmia/Heart Rhythm Problem				Elevated Red Blood Cell Count (Polycythemia)		

PAST SURGICAL HISTORY Please list all surgeries you have had.

SURGERY	DATE		SURGERY	DATE

Name: ______________________________ DOB: ____________________

FAMILY HISTORY Please check ☑ all that apply.

Condition		YES		Condition		YES
Asthma				Sleep Apnea		
Cancer				Stroke		
Where?				Thyroid Disorder		
COPD				Heart Disease		
Diabetes				Other:		
Hypertension						

SOCIAL HISTORY Please check ☑ all that apply.

		YES	NO
Do you smoke?			
How many years have you smoked?			
Are you a former smoker?			
When did you quit smoking?			
Have you tried to quit?			
Do you drink alcohol?			
How many alcohol drinks per day?			
What is you occupation?			

When was your last flu shot? ______________________________

Have you had a pneumonia shot? YES NO When? ____________________

Do you have a Living Will or Advance Directive? YES NO

Name: ______________________________ DOB: ______________

THE EPWORTH SLEEPINESS SCALE

Use the following scale to rate how likely you are to doze or fall asleep during each of the following situations. This refers to your usual way of life in recent times.

0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing
3 = high chance of dozing

	Chance of Dozing
Sitting and reading	________
Watching TV	________
Sitting, inactive in a public place (a theater, meeting, seminar)	________
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	________
SCORE:	

1. Why are you seeing a sleep specialist? ______________________________
2. How long has this problem bothered you and how often does it occur? ______________________________
3. Do any other members of your family have sleep problems? ______________________________

Please check ALL that apply:

Awaken short of breath, choking or gasping ___
Awaken with heartburn, belching, or coughing ___
Have crawling/aching feelings in legs ___
Sweat excessively at night ___
Fall asleep when laughing/crying ___
Notice parts of your body jerking ___
Kick during the night ___
Wake with pain in neck, spine, joints ___
Have morning jaw pain ___
Notice heart pounding, beating irregularly day/night ___
Feel unable to move/paralyzed when waking or falling asleep___
Problems at school/work because of sleepiness___

History of Tonsillectomy ___
Fall asleep or doze while driving ___
Wake with stiff, sore/aching muscles ___
Have vivid dream-like scenes upon awakening/falling asleep ____
Frequent Headaches ___
Problems with focus & attention ___
Memory Problems ___
Have loss of muscle tone when extremely emotional___
Snore Loudly ________
Grind teeth during sleep ___
Bedwetting____
Fall asleep during the day ___

Name: ______________________________ **DOB:** ______________

5. Does your sleep problem interfere with your social life/activity? How? ______________
____

6. How many hours of sleep do you usually get per night? ______________

7. What time do you usually go to bed on Weekdays?__________Weekends?__________

8. How long does it take for you to fall asleep? ______________

9. How many times do you typically wake up at night? ______________

10. What time do you get up in the morning on WEEKDAYS? ________ WEEKENDS? ________

11. What disturbs your sleep? ______________________________

12. With whom are you now living? (wife, husband, children, parents, etc., please list ages)
____

13. Occupation? ______________ Do you work split shifts or rotating (variable) shifts?________

14. Do you drink coffee or tea within 2 hours before you go to bed? **( ) YES ( ) NO**
15. Do you do physical exercise before bedtime? **( ) YES ( ) NO**
16. Do you read and/or watch TV before falling asleep? **( ) YES ( ) NO**
17. Do you take naps during the afternoon or evening? **( ) YES ( ) NO**
18. Do you wake from naps feeling rested? **( ) YES ( ) NO**
19. Have you ever been knocked unconscious or had serious injury to your head? **( ) YES ( ) NO**
Please Explain______________________________

20. **CIRCLE** IF YOU HAVE YOU EXPERIENCED ANY OF THE FOLLOWING RECENTLY:

Depression	**Anger**	**Anxiety**	**Loneliness**	**Suicidal Thoughts**
Hopelessness	**Fears**	**Fatigue**	**Nightmares**	**Low self-esteem**

24. Have you attempted suicide in the last six months? ______________

25. Are you contemplating causing harm to yourself at this point and time? ______________

26. Have you been under the care of a mental health practitioner (e.g., psychiatrist, psychologist) in recent time's or currently? ____________If yes, who? ______________

29. Have you had a sleep study before? YES NO When and Where?______________

30. Do you have a CPAP Machine? YES NO If yes, where was it purchased? ________