NEW MEXICO SLEEP LABS *We won't rest till you do...*

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Law Enforcements

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are acquired to report certain communicable disease to the state's public health department.

Appointment Reminders

Your health information will be used by our staff to send you appointment reminders, leave messages on voice mail and with family members.

Other Uses and Disclosures that Require Your Authorization

Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of consultations / sleep study benefits to Dr. Gonzalo Diaz / El Paso Sleep Center For services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.
Yo, autorizo el pago por consultas o estudios del sueno a el Dr. Gonzalo Diaz / El Paso Sleep Center de su parte ya sea en persona o bajo su supervision. Yo entiendo que yo sere responsible por la porcion que mi aseguranza de salud no tiene cobertura.

AUTHORIZATION TO RELEASE INFORMATION

I, hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
Yo, autorizo a el Dr. _____ propocionar informacion medicas que sean necesarias para mi cuidado de salud o para procesar reclamos de aseguranza.

MEDICARE / MEDICAID

I, certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
Yo, certifico que toda la informacion que he proporcionado para el pago de mis servicios es veridico. Yo, autorizo proporcionar toda mi documentacion medica. Yo, autorizo el pago departe de mi aseguranza para el pago de mi cuidado.

AUTHORIZATION OF PATIENTS RELEASE OF INFORMATION

During the course of your treatment at the El Paso Sleep Center the doctor may prescribe a CPAP unit for your use at home. If the El Paso Sleep Center is not in the network for your particular insurance, the El Paso Sleep Center will forward your information to a medical equipment company to provide you with any medical equipment that may be necessary.
I authorize El Paso Sleep Center to release patient information to a medical equipment company that would be able to further assist me in regards of receiving the CPAP unit or any other medical supplies.

PLEASE PRINT

Patient Name: _____ Date: _____

Parent / Guardian: _____ Date: _____

Signature: _____ Date: _____

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EPWORTH SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you "Have Not" done some of these recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number of each situation:

0 = No Chance of Dozing
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching T.V.	
Sitting inactive in a public place (e.g. movies / theater)	
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	

73. List any medications your child has been prescribed to help with the sleep problem. Give the names, dosage, time they were taken, how long they were taken for, any beneficial effects, why they were stopped. (Start with the first medication taken).

Medication	Dose	Time	Length	Effect	Stopped

74. Please give the following family information:

	Age	Illnesses
Mother:		
Father:		
Brothers:		
Sisters:		

68. Do you consider your child's sleep to be: Mild/Moderate/Severe

69. Please add any other comments about your child's sleep problem that you think are relevant:

70. Please list all people whom you have consulted about your child's sleep problem. Starting with the first, list the date, name, degree, specialty, investigations, treatment and outcome of all treatments (give details of medications on the next page).

Date	Name	Degree	Specialty	Investigation.	Treatment

71. Please list all medical illness that your child has been treated for in the past or is now under treatment for. Give the date, name of illness, treatment and outcome.

72. Operations:

52. Does your child ever awaken suddenly with a scream and appear inconsolable? Yes/No/DK
    If so, how often? _____ Times Per Month

53. Does your child sleep walk? Yes/No
    If so, how often? _____ Times Per Week

54. If your child sleep walks, has he ever injured him/herself? Yes/No

55. Does your child ever wet the bed? Yes/No
    If so, how often? _____ Times Per Week

56. Does your child snore at night? Yes/No

57. Does the snoring occur every night? Yes/No
    If not, how often does it occur? _____ Times Per Week

58. Does your child ever seen to stop breathing while asleep? Yes/No
    If so,for how long? _____ Seconds

59. Has your child ever had a tonsillectomy or adenoidectomy? Yes/No
    If so, please give the date:

60. Please state when your child was able to sleep consistently without any problems:
    Never/ _____ Years/Months Ago

61. What time did your child then go to bed at? _____ pm
    How long did it take your child to fall asleep? _____ Minutes

62. Did your child awaken during the night? Yes/No
    If so, how often and for how long (times): _____ Minutes

63. What time did your child awaken in the morning? _____ am

64. At what time would you like your child to fall asleep now? _____ pm

65. How long would you like your child to sleep for? _____ Hours

66. What time would you like your child to awaken in the morning? _____ am

67. For how long do you think normal children of your child's age sleep? _____ Hours

35. How does a poor rights sleep affect your child the next day?

36. Does your child feel sleepy during the day? Yes/No

37. Does your child nap during the day? Yes/No
If so, how often and for how long? Time _____ Hrs. _____ Minutes _____

38. What time of day does your child nap? _____ am _____ pm

39. If there are no naps, what time of day does he/she your feel most tired? _____ am _____ pm

40. What time of day does your child seem most alert? _____ am _____ pm

41. As the sleep period approaches, does your child become more alert? Yes/No

42. Do you think a poor night's sleep affects your child's school performance the next day? Yes/No

43. Has the teacher comment on this? Yes/No

44. Does your child toss and turn in bed? Yes/No

45. Have you ever noticed your child's head rocking from side to side at night? Yes/No
If so, please describe:

46. How often does this behavior occur? _____ Times

47. What time of night is this activity likely to occur? _____ am/pm

48. Does your child complain of aching legs at bedtime? Yes/No

49. Does your child moves his/her legs around in bed at night? Yes/No/DK

50. Do your child's legs jerk while he/she is asleep at night? Yes/No/DK

51. Does your child have nightmares? Yes/No
If so, at what age did they begin? _____ Years
How often do they occur? _____ Times Per Night

19. What is the longest time it has taken your child to fall asleep?
_____ Hrs. _____ Mins.

20. What do you think prevents your child from falling asleep?
Fears/Loneliness/Not Sleepy/Worries/Other: _____

21. Do you get annoyed / angry when your child cannot sleep? Yes/No

22. How often does your child cry him/herself to sleep _____ Times Per Week.

23. Do you ever let your child cry in bed in order to get to sleep? Yes/No
If so, how long do you let the child cry: 10 / 20 / 30 minutes / as long as it takes

24. When unable to fall asleep, does your child get out of bed? Yes/No
If so, how long after getting into bed: _____ Hrs. _____ Mins.

25. Once out of bed, what does your child do?
_____
_____

26. How long is your child up for? _____ Hrs. _____ Mins.

27. When your child returns to bed, how long does it take to fall back to sleep?
_____ Hrs. _____ Mins.

28. If the child does not get out of bed, how long does it take to fall back to sleep?
_____ Hrs. _____ Mins.

29. Once having fallen asleep, how long does your child sleep for?
_____ Hrs. _____ Mins.

30. Does your child awaken during the night? Yes/No
If so, on average how long will your child be awake for? _____ Hrs. _____ Mins.

31. How often does your child awaken during the night? _____ Times

32. What time does your child finally awaken in the morning? _____ am

33. What time does your child get out of bed in the morning? _____ am

34. How does your child seem on awakening in the morning?
_____

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5. Does your child do any of the following in bed at night?
   Read Yes/No
   Watch TV Yes/No
   Listen to the radio Yes/No
   Other: _____
   _____

6. Will your child fall asleep alone in bed? Yes/No

7. In order to sleep, dose your child often need a special toy or object? Yes/No
   If so, describe: _____

8. Does your child often need a bottle in order to go to sleep? Yes/No

9. What type of bed does your child sleep in?
   Crib/Single Bed/Double Bed/Other _____

10. Does your child sleep alone? Yes/No

11. Which side of the body does your child sleep on:
    Left Side/Right Side/Back /Face Down

12. What time is the bedroom light turned off: _____ pm/am

13. Does a parent or the child turn off the light? Parent/ Child

14. Is your child bothered by environmental noises at night? Yes/No
    _____
    _____
    _____

15. As an infant, was your child "colicky"? Yes/No

16. As an infant, did your child require any of the following devices to get to sleep?
    Swing/Snuggly/Car Ride/Being Held/Other: _____

17. On average how long does it take your child to fall asleep? _____ Hrs. _____ Mins.

18. What is the quickest time it has taken your child to fall asleep in the last 2 weeks?
    _____ Hrs. _____ Mins.

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SleepMultiMedia

Name: _____ Date: _____ Age:_____

SLEEP DISORDER CENTER
PEDIATRIC QUESTIONNAIRE

Please complete this questionnaire and return it to the physician who interviews you and your child at the time of the Initial Evaluation

In answering the questions are as complete as possible. The more information that is given the more complete will be the evaluation of your child's condition.

Use the back of the previous page to complete detailed answers or to add additional information which is relevant.

Circle the most appropriate answers in the questionnaire.

DK means Don't Know **NA** means Not Applicable

The Sleep Disorder Center physicians will go over the answers with you. We look forward to being able to evaluate your child's problem and to be able to provide therapeutic advice.

1. Please describe in your own words as briefly as possible your child's main problem?

   _____

   _____

2. When was the very first time this problem began? _____ Years Ago

3. List any medications that your child is currently taking to help with the sleep problems:

Preparation	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Describe what your child usually does during the last 30 minutes before bedtime:

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West
4305 N. Mesa Suite B
El Paso, TX 79912

Far East
3030 Joe Battle
El Paso, TX 79938

PRE-REGISTRATION INFORMATION

Appt. Time & Date: _____ *Dr.* _____

Last Name: _____ *First Name:* _____ *MI* _____ *Gender: M / F*

Date of Birth: ___/____/____ *Social Security Number:* _____

Guarantor Name (if different from patient): _____

Address: _____ *City:* _____ *State:* _____ *ZIP:* _____

Home #: (___)_____ *Work #:* (___)_____ *Cell #:* (___)_____

Referring Physician: _____ *PCP:* _____

Emergency Contact: _____ *Relationship:* _____ *Phone #:* (___)_____

How did you hear about EL PASO SLEEP CENTER? _____