Jacksonville Sleep Center

Baptist Medical Center Beaches

Thank you for choosing the Jacksonville Sleep Center. We have an appointment scheduled for you on _____ at _____.

Enclosed is your sleep questionnaire. Please complete the questionnaire and bring it to your appointment.

Our office location is 6930 Bonneval Road # 2 Jacksonville, FL 32216. Please contact our office at 904.854.6899 if you have any questions.

Thank you again for choosing Jacksonville Sleep Center. We look forward to serving you.

BAPTIST HEART SPECIALISTS
Baptist Health Jacksonville

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Relation to Patient _____

Patient Information

Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email _____

Date of Birth _____ Sex _____ Marital Status _____

Race: ❑ Unknown ❑ African American ❑ Asian ❑ Caucasian ❑ Chinese ❑ Filipino ❑ Hispanic ❑ Japanese
❑ Native American ❑ Native Hawaiin ❑ Pacific Islander ❑ Other_____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown ❑ Unrecorded

Primary Language_____

Social Security Number _____

(If a minor): Mother's Name_____ Home Phone #_____

Father's Name _____ Home Phone #_____

Emergency Contact Information

Contact Name _____

Relationship to Patient _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone #_____

Primary Insurance Name

Insurance Company _____

Group #_____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Company _____

Group #_____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Referred by _____

BAPTIST HEART SPECIALISTS
Baptist Health Jacksonville

Authorizations and Acknowledgments

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance Information

- If you are covered by Medicare,Tricare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit. **Methods of Payment: Cash, Check, Visa, MasterCard and Discover.**
- All self-pay patients are expected to pay for services in full at the time that services are rendered.
- We will file with all insurance plans for our professional fees for any hospital admissions.
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

Worker's Compensation

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

Completion of Forms

Baptist Heart Specialists reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Authorization for Payment

I hereby authorize Baptist Heart Specialists to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

_____ _____
Responsible Party Signature Date

_____ _____
Patient's Name (Please Print)) Date of Birth

Notice of Privacy Practices

I acknowledge receipt of a copy of the Baptist Heart Specialists Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at Baptist Heart Specialists, I authorize Baptist Heart Specialists to use and disclose information from and release copies of my (the patient's) medical records in accordance with Baptist Heart Specialists' policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

_____ _____
Patient or Parent (Guardian) Date

BAPTIST HEART SPECIALISTS
Baptist Health Jacksonville

Health Care Status Authorization

Declaration

I, _____ (name of patient) hereby give authorization to Baptist Heart Specialists for the release of information concerning the status of my health care, including results of laboratory and radiology tests and to discuss my plan of treatment with:

_____
Name of Authorized Individual

_____
Relationship to Patient

I understand that I may revoke this authorization at any time.

_____
Patient Signature

_____
Witness

_____
Date

SLEEP DISORDER QUESTIONNAIRE

The Epworth Sleepiness Scale

Name:_____

How likely are you to doze off or fall asleep in the situations described in the box below, 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 things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0=Would never doze, 1=Slight chance of dozing, 2=Moderate chance of dozing, 3=High chance of dozing

Situation	Score
Sitting and reading	[ ]
Watching TV	[ ]
Sitting inactive in a public place (e.g. a theatre 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 a lunch without alcohol	[ ]
In a car, while stopped for a few minutes	[ ]
Total	

The score is simply the addition of all eight answers. Less than 10 is considered normal.

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1. Are you bothered by sleepiness under other circumstances? Yes ☐ No ☐

   If yes, describe: _____

2. Have you been in a car accident due to falling asleep at the wheel? Yes ☐ No ☐
3. Have you had a near miss due to falling asleep at the wheel? Yes ☐ No ☐

   If yes, describe: _____

4. Have you had other types of accidents because of sleepiness: Yes ☐ No ☐

   If yes, describe: _____

5. If employed, what are your working hours? Start: _____ AM/PM Stop: _____ AM/PM
6. How long have you been on this work schedule? _____
7. What is your current marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

   If married, for how long? _____ Years

   Do you take naps? Yes ☐ No ☐ If so, how often? _____ Are they refreshing? Yes ☐ No ☐

SLEEP DISORDER QUESTIONNAIRE

Medical History

Name:_____

Please place an "X" by any problem or illness you have or have had

_____ Heart Disease	_____ Seizures	_____ Heartburn
_____ Hernia	_____ Impotence	_____ Bladder Trouble
_____ Ringing of the ears	_____ Eye Trouble	_____ Kidney Trouble
_____ Headaches	_____ Gout	_____ Dizziness
_____ Epilepsy	_____ Hearing Trouble	_____ Asthma
_____ Black Outs	_____ Pneumonia	_____ Bronchitis
_____ Hemophilia (Bleeder)	_____ Meningitis	_____ Fainting
_____ Ulcers	_____ Heart Attack	_____ Cancer
_____ Prostate Trouble	_____ Depression	_____ High Blood Pressure
_____ Mental Problems	_____ Venereal Disease	_____ Low Blood Pressure
_____ Back Trouble	_____ Arthritis	_____ Allergies
_____ Tuberculosis	_____ Muscle Cramp	_____ Sleep Disorders*

*Past sleep studies or surgery related to sleep disorders:

Initial Study: _____ Location: _____ Physician: _____

CPAP/BIPAP _____ Location: _____ Physician: _____

Post ENT Study: _____ Location: _____ Physician: _____

If you use the following equipment , please complete the blanks:

CPAP Pressure: Cm/H2O BIPAP Pressure: Oxygen: LPM

Has anyone in your family been diagnosed with a sleep problem? Yes ☐ No ☐ Relationship: _____

What is the average number of drinks you have per day of: Caffeinated beverages:_____ Alcoholic beverages: _____

Do you smoke? Yes ☐ No ☐ For how long?_____ Number per day?_____

What is your present weight? _____ Height?_____ What is your neck size? _____

Excluding pregnancy, what has the range of your weight been over the past five (5) years? _____

Are you allergic to any medication? Yes ☐ No ☐ Medication name(s):_____

SLEEP DISORDER QUESTIONNAIRE

Sleep History

Check any of the following symptoms that you currently have when sleeping or trying to sleep.

☐ Toss & turn	☐ Fall out of bed	☐ Bed Wetting
☐ Heartburn	☐ Sour Belches	☐ Pain
☐ Regurgitation	☐ Night Sweats	☐ Teeth Grinding
☐ Cold feet	☐ Sleep Walking	☐ Sleep talking
☐ Nightmares	☐ Irresistible urge to move legs	☐ Legs jerking

1. Do you snore in all positions? Yes ☐ No ☐ If not, when? _____
2. What time do you usually go to bed?_____ AM ☐ PM ☐
3. How many times do you awaken during the night and why? _____
4. What time do you usually wake up in the morning?_____ AM☐ PM ☐
5. Do you usually sleep longer when you do not have to get up? Yes ☐ No ☐ How long?_____
6. How many hours of actual sleep do you think you get each night on average?_____
7. Upon wakening in the morning, do you feel: Completely rested ☐ Partially rested ☐ Not rested at all ☐

Check any of the following symptoms you have to an excessive degree:

☐ Fatigue	☐ Inability to concentrate	☐ Memory impairment
☐ Anxiety	☐ Depression	☐ Irritability
☐ Change in personality	☐ Family problems	☐ Loss of appetite

List all medications (prescribed or otherwise) that you are currently using or have used within the last 30 days. Also list any medication you have used in the past to help your sleep problem: (*add additional sheet if necessary)*

Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken:	_____
Medication:	_____	Amount:	_____	Last Taken: :	_____
Medication:	_____	Amount:	_____	Last Taken:	_____

PATIENT CHECKLIST QUESTIONNAIRE

Please check all statements that apply.

_____ I have been told that I snore.
_____ I often feel sad or depressed.
_____ I have been told that I hold my breath while sleeping.
_____ I have trouble concentrating at work or school.
_____ I have high blood pressure.
_____ I have fallen asleep while driving.
_____ I have been told by friends and family that I am often grumpy or irritable.
_____ I have experienced vivid dreamlike scenes upon falling asleep or awakening.
_____ I sweat excessively during the night.
_____ I have fallen asleep in social settings such as the movies or parties.
_____ I have noticed my heart pounding or beating irregularly during the night.
_____ I have dreams soon after falling asleep or during naps.
_____ I get morning headaches.
_____ I tend to loose muscle tone when I get emotional (example: you will laugh or cry and your muscles will feel weak, sometimes to the point the you will pass out)
_____ I suddenly wake up gasping for breath.
_____ I have had episodes of feeling paralyzed right when I wake up or right when I am falling asleep.
_____ I am overweight.
_____ I wake up at night with an acid/sour taste in my stomach.
_____ I seem to be losing my sex drive.
_____ I wake up at night coughing or wheezing.
_____ I often feel sleepy and struggle to remain alert.
_____ I wake up suddenly during the night feeling like I am choking.
_____ I frequently wake with a dry mouth or sore throat.
_____ I experience muscle tension in my legs at times other than when exercising.
_____ I have difficulty falling asleep.
_____ I have noticed (or others have commented) that parts of my body jerk during sleep.
_____ I have thoughts racing through my mind preventing me from sleeping.
_____ I have been told that I kick at night.
_____ I wake up and cannot go back to sleep.
_____ I experience an aching or crawling sensation in my legs while trying to go to sleep.
_____ I worry about things and have trouble relaxing.
_____ I experience leg pain or cramps at night.
_____ I wake up earlier in the morning than I would like.
_____ I occasionally cannot keep my legs still at night; I have to move them to feel comfortable.
_____ I lie awake for half an hour or more before falling asleep.
_____ I feel sleepy during the day even though I slept through the night.
_____ I have a history of coronary artery disease, heart attack, cardiac surgery or congestive heart failure.
_____ I am already on CPAP/BIPAP and pressure setting.
_____ I am on oxygen.
_____ I have had surgeries for sleeping or sleep apnea.
_____ I have asthma.

Jacksonville Sleep Center
Baptist Medical Center Beaches

Directions to the Sleep Center

6930 Bonneval Rd, Suite #2
Jacksonville, FL 32216
Phone: 854-6899

From the Northside –
Take 95 South exit right on Butler Blvd. Turn right on to Bonneval Rd. On the round-about take the 2nd turn to the right, then first left into parking lot of IDS (interior design). Jacksonville Sleep Center is around the end of the parking lot. 6930 #2 Bonneval Rd.

From the Westside and Orange Park –
Take I-295 S merge onto I-95 N via EXIT 61B take EXIT 344 toward SR-202/BUTLER BLVD/JAX BEACHES. Follow the round about to go West on J Turner Butler. Turn right onto Bonneval Rd. On the round about take the 2nd turn on the right, then first left into parking lot of IDS(interior design) Jacksonville Sleep Center is around the end of the parking lot. 6930 #2 Bonneval Rd.

From the Beaches –
Take Butler Blvd West to Bonneval Rd, turn right. On the round about take the 2nd turn on the right, then first left into parking lot of IDS(interior design) Jacksonville Sleep Center is around the end of the parking lot. 6930 #2 Bonneval Rd.

From Mandarin / Julington Creek –
San Jose Blvd and turn right on Baymeadows Rd. Turn left on Phillips Highway. Turn right on J Turner Butler Blvd. Turn left on Bonneval Rd. On the round about take the 2nd turn on the right, then first left into parking lot of IDS(interior design) Jacksonville Sleep Center is around the end of the parking lot. 6930 #2 Bonneval Rd.