West Houston ENT & Sleep Center, PA
12606 West Houston Center Blvd #220, Houston Tx 77082; Tel: 281.556.1102; Fax: 281.556.1340

REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Email_____
Patient Last Name_____ First Name_____ Initial_____
Street Address_____
City_____ State_____ Zip_____
Sex M F Age_____ Birth date_____ Single Married Widowed Separated Divorced

Social Security #_____ Driver's License #_____

Insured Name_____ How and where did you learn about this clinic?_____
Last Name First Name Initial
Relationship To Insured Self Spouse Child Other
Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ Full-time Part-time City State Zip Years Employed
SPOUSE (PARENT)	Name_____ Birthdate_____ SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ _____ Address_____ Phone_____ Occupation_____ City State Zip Full-time Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: ID #:
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: ID #:
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? Yes No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant Yes No Pacemaker Yes No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u>, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA</u>. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Name of Patient or Personal Representative	Description of Personal Representative's Authority

Payment Policy

***** Please note: ALL PAYMENT IS DUE AT THE TIME OF SERVICE *****

In order for Dr. James Ludwick to adequately evaluate and diagnose your complaint/illness you may require an in-office procedure. Common diagnostic procedures include:

- Nasal Endoscopy/Nasopharyngoscopy
- Flexible Laryngoscopy
- Removal of impacted cerumen to allow visualization of the ear drum
- Use of microscope

In addition, common in-office therapeutic procedures include:

- Inferior turbinate reduction
- removal of nasal or ear foreign bodies
- cerumen removal
- Pillar Procedure
- biopsies
- nasal debridement

You may be responsible for the charges associated with these procedures which typically range from $50 - $250 ($90 - $1500 for therapeutic procedures). This will depend on your specific health care benefits from your insurance provider. As a courtesy, at the time of your visit we will do our best to notify you of any co-insurance or deductibles which apply to your policy, *but it is ultimately your responsibility to know what your health care policy covers*.

These payments are expected at the time of service unless prior written arrangements have been made with our office. If, upon receiving your explanation of benefits (EOB) from your insurance carrier, an overpayment was made on your part, a refund will be mailed to the address on file with our office.

Please feel free to ask the receptionist if you have any questions regarding this policy so we can minimize any confusion concerning our charges.

Thank you,

West Houston ENT & Sleep Center
Billing and Insurance Dept.

I acknowledge that I may be responsible for payment due at the time of service other than my office visit co-pay or deductable due to my benefit plan.

X_____ **X**_____

Patient/Guardian Signature **Date**

X_____

Patient name

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New Patient Health History

IN YOUR OWN WORDS, WHAT BRINGS YOU TO SEE US TODAY?_____

_____

PLEASE TELL US YOUR: HEIGHT_____ **WEIGHT**_____**lbs**

PAST HEALTH HISTORY: Has your doctor ever told you that you have any of the following (These are **NOT** symptoms)?

Face:
- Skin Cancer ❑No ❑Yes When?_____
  - Type ❑Basal Cell ❑Squamous Cell ❑Melanoma
- Bell's Palsy/Facial weakness ❑No ❑Yes When?_____

Ears:
- Recurrent Infections ❑No ❑Yes When?_____
- Hearing Loss ❑No ❑Yes When?_____
- Ear Fluid ❑No ❑Yes When?_____
- Cholesteatoma ❑No ❑Yes When?_____

Nose & Sinus:
- Nasal Allergies ❑No ❑Yes When?_____
- Sinusitis ❑No ❑Yes When?_____
- Nasal Polyps ❑No ❑Yes When?_____
- Nose Bleeds ❑No ❑Yes When?_____

Cardiovascular:
- Arrhythmia ❑No ❑Yes When?_____
- Heart Valve Disease ❑No ❑Yes When?_____
- High Blood Pressure ❑No ❑Yes When?_____
- High Cholesterol ❑No ❑Yes When?_____
- Heart Attack ❑No ❑Yes When?_____

Pulmonary:
- Asthma ❑No ❑Yes When?_____
- Emphysema/COPD ❑No ❑Yes When?_____
- Sleep Apnea ❑No ❑Yes When?_____
- Tuberculosis ❑No ❑Yes When?_____
- Use oxygen at home ❑No ❑Yes When?_____

Have you ever had:
- Hepatitis ❑No ❑Yes When?_____
- HIV ❑No ❑Yes When?_____
- Mononucleosis ❑No ❑Yes When?_____

Stomach/Digestive:
- Reflux ❑No ❑Yes When?_____
- Liver Disease ❑No ❑Yes When?_____
- Gastric/duodenal Ulcers ❑No ❑Yes When?_____

Kidney:
- Kidney Stones ❑No ❑Yes When?_____
- Renal Failure ❑No ❑Yes When?_____

Endocrine
- High blood calcium ❑No ❑Yes When?_____
- Diabetes ❑No ❑Yes When?_____
- Thyroid Disease ❑No ❑Yes When?_____
  - ❑Hyperthyroidism ❑Hypothyroidism
  - ❑Nodule

Blood/Lymph Nodes:
- Anemia ❑No ❑Yes When?_____
- Bleeding Disorder ❑No ❑Yes When?_____
- Leukemia/Lymphoma ❑No ❑Yes When?_____

Have you ever been diagnosed with cancer?
❑No ❑Yes **Please list location and year diagnosed.**
Location_____Year_____
Location_____Year_____

Neurological/Psychiatric (please check which applies to you)
❑Stroke ❑Parkinson's ❑Alzheimer's ❑Seizures
❑Depression ❑Anxiety Disorder ❑Panic Attacks

Have we missed anything? _____
_____

SURGERIES: (Please include type or location and year of surgery)
❑EAR TUBES ❑TONSILLECTOMY ❑SINUS SURGERY
❑SEPTUM ❑SLEEP SURGERY ❑RHINOPLASTY
OTHER:_____
_____

Have you ever been hospitalized? ❑No ❑Yes

Have you ever had a problem with anesthesia? ❑No ❑Yes
Reaction_____

CURRENT MEDICATIONS:(Includes all prescription, over-the-counter medications, herbal and vitamin supplements)

❑CHECK **HERE** IF YOU DON'T TAKE ANY MEDICATIONS

Name of Medication	Dose	Times/day

Do you take: ❑Aspirin ❑Plavix ❑Coumadin ❑Ginko Biloba ❑Ginseng ❑Echinacea ❑Garlic

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***MEDICATION ALLERGIES*:** ❑CHECK **HERE** IF YOU HAVE NO MEDICATION ALLERGIES

Name of Medication	Type of Reaction (ex: rash, hives, swelling)

SOCIAL HISTORY:

I think my overall health is: ❑Excellent ❑Good ❑Average ❑Fair ❑Poor
Marital Status ❑Married ❑Separated ❑Divorced ❑Widowed ❑Single ❑Significant Other
Children? ❑No ❑Yes Number____
Occupation:_____❑Full Time ❑Part time

Are you a Jehovah Witness? ❑No ❑Yes
Exercise regularly? ❑No ❑Yes **Days/Week**:_____
Have you *ever* used illicit drugs? ❑No ❑Yes
Do you *currently* use them? ❑No ❑Yes
Type: _____

Do you use or have you used tobacco products? ❑No ❑Yes
|| **If yes, year began?** _____
|| ❑Cigarettes Packs/day_____❑Chew Tobacco
|| ❑Cigar/Pipe Number/day_____
|| **Quit?**❑No ❑Yes **Year** _____
|| **Do you drink alcoholic beverages?** ❑No ❑Yes
|| **If yes** ❑Occasionally ❑Daily (**Drinks/day)**_____

How many cups of caffeinated beverages do you drink/day? || ❑1-3 ❑3-5❑5-7 ❑>7

FAMILY HISTORY:

Problems with anesthesia	❑Mother	❑Father	❑Brother	❑Sister
Ears:				
Hearing loss before age 20	❑Mother	❑Father	❑Brother	❑Sister
Hearing loss after age 20	❑Mother	❑Father	❑Brother	❑Sister
Nose & Sinus:				
Nasal Allergies	❑Mother	❑Father	❑Brother	❑Sister
Nose Bleeds	❑Mother	❑Father	❑Brother	❑Sister
Nasal Polyps	❑Mother	❑Father	❑Brother	❑Sister
Cardiovascular				
Heart Attack	❑Mother	❑Father	❑Brother	❑Sister
High Cholesterol/Heart Disease	❑Mother	❑Father	❑Brother	❑Sister
High Blood Pressure	❑Mother	❑Father	❑Brother	❑Sister
Pulmonary:				
Asthma	❑Mother	❑Father	❑Brother	❑Sister
Lung Cancer	❑Mother	❑Father	❑Brother	❑Sister
Gastrointestinal				
Stomach/Esophageal Cancer	❑Mother	❑Father	❑Brother	❑Sister
Reflux	❑Mother	❑Father	❑Brother	❑Sister
Nervous System				
Stroke	❑Mother	❑Father	❑Brother	❑Sister
Brain Tumors	❑Mother	❑Father	❑Brother	❑Sister
Blood & Lymph Nodes				
Bleeding/Clotting Disorder	❑Mother	❑Father	❑Brother	❑Sister
Leukemia/Lymphoma	❑Mother	❑Father	❑Brother	❑Sister

Other:_____

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New Patient Health History

REVIEW OF SYSTEMS:

General Health Problems
❑Fatigue ❑Fever/Chills ❑Headache ❑Loss of appetite
❑Night Sweats ❑Recent Illness ❑Weight loss

Eye
❑Blurry Vision ❑Bulging of eyes ❑Double Vision
❑Itchy/Watery Eyes

Ear
❑Ear Pain ❑Hearing Loss ❑Drainage
❑Infections #/yr_____ ❑Dizziness/Vertigo
❑Ringing ❑Fullness ❑Popping Sensations

Nose & Sinus
❑Nasal Congestion ❑Nasal Drainage ❑Post-Nasal Drip
❑Facial Pain ❑Nose Bleeds ❑Nasal Obstruction

Mouth & Throat
❑Hoarseness ❑Change in Voice ❑Snoring
❑Ulcers ❑Sore Throat ❑Witnessed Apnea
❑Recurrent Throat Infections #/yr_____
❑Difficulty Swallowing ❑Painful Swallowing
❑Sense a "lump" in throat

Neck
❑Neck Mass ❑Pain ❑Lymphadenopathy

Endocrine/Glands
❑Change in thirst/appetite ❑Feel cold all the time
❑ Neck has enlarged ❑Feel hot all the time
❑Change in Appetite ❑Weight Loss

Allergy
❑Food intolerances ❑Itchy/watery eyes
❑Mold Allergy ❑Seasonal allergies
❑Receive Allergy Shots ❑Sneezing
❑Allergy symptoms all year long

Pulmonary
❑Non-productive cough ❑Wheezing
❑Productive cough ❑Shortness of Breath
❑Stridor ❑Pneumonia ❑Cough up blood

Cardiovascular
❑Swelling of Ankles/legs ❑Chest Pain
❑Blacking out/fainting ❑Irregular Heartbeat

Stomach/GI System
❑Cough while eating ❑Heartburn/Reflux
❑Nausea ❑Stomach Problems
❑Vomiting

Genito/Urinary
❑Are You Pregnant? ❑Urinate Frequently at Night

MusculoSkeletal
❑Back Pain ❑Muscle Pain ❑Muscle Cramps
❑Bone Pain

Nervous System
❑Balance Problems ❑Numbness ❑Seizure
❑Pass Out ❑Weakness

Integument/Skin
❑ Change in Skin Lesion ❑Form large scars
❑Non-healing Wound ❑Rash

Blood/Lymph Nodes
❑Bleed Excessively ❑Bruise Easily
❑Swollen Glands ❑Frequent Nose Bleeds

Psychiatric
❑Depression ❑Anxiety ❑Excessive Stress

Do you have any of the following symptoms:
❑Spouse/significant other says you stop breathing when sleeping ❑Snore Loudly ❑Dry mouth in the morning
❑Sleepy during the day ❑Uncontrollable sleep attacks ❑Restless sleep
❑Creepy/crawling sensations in legs when trying to sleep ❑Leg kicking while sleeping
❑Wake up feeling paralyzed ❑Hallucinate when waking up/falling asleep
❑Difficulty falling asleep ❑Difficulty staying asleep ❑Waking up too early
❑Worrying at bedtime ❑Take sleeping pills ❑Drink alcohol to help you fall asleep

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New Sleep Patient Information

EPWORTH SLEEPINESS SCALE

How LIKELY are you to DOZE off or FALL ASLEEP in the following situations, in contrast to feeling just tired? This refers to you 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. Please check one box per line.

-- CHANCE OF DOZING OFF --

Never	Slight	Moderate	High	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting, inactive in a public place (example, a theater or a 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
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

BRIEF SLEEP SYMPTOM CHECKLIST *(Please check the boxes that best describe you)*

Never	Rarely	Frequently	Always	
☐	☐	☐	☐	I snore loudly
☐	☐	☐	☐	I awaken gasping or choking for breath
☐	☐	☐	☐	I awaken in the morning feeling unrefreshed
☐	☐	☐	☐	I have problems falling asleep or staying asleep (insomnia)
☐	☐	☐	☐	My sleep is very restless
☐	☐	☐	☐	My sleep is disturbed by unusual behaviors (for example: nightmares, sleepwalking, dream enactments, tongue biting, bedwetting, etc.)
☐	☐	☐	☐	I fall asleep while driving
☐	☐	☐	☐	I've been told that I stop breathing in my sleep (told by _____)

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New Sleep Patient Information

SLEEP SCHEDULE ***(Please provide the following information)***
What time do you get INTO bed on WEEKDAYS? _____AM/PM WEEKENDS?_____AM/PM
What time do you get OUT of bed on WEEKDAYS? _____AM/PM WEEKENDS?_____AM/PM

Do you nap? ❑No ❑Yes ____times per week How long are the naps?_____minutes_____hours
Do you awaken refreshed? ❑No ❑Yes Do you feel more refreshed on the weekends if you sleep in?❑No ❑Yes

Once in bed, how long does it typically take you to fall asleep? ❑<15mins ❑<30mins ❑<60mins ❑Over an hour
Do you work 2nd or 3rd shift? ❑No ❑Yes What Shift? __2nd __3rd

Have you ever had a sleep study? ❑No ❑Yes Have you ever used CPAP? ❑No ❑Yes

What problem causes you to seek our help?_____

How does this problem affect your life?_____

CHECK the box for each problem you CURRENTLY HAVE

- ❑ Loud snoring
- ❑ Frequent awakenings at night
- ❑ Choking for breath at night
- ❑ Gasping during sleep
- ❑ I've been told that I stop breathing when asleep
- ❑ Restless sleep
- ❑ Awaken not refreshed
- ❑ Crawling feelings in legs when trying to sleep
- ❑ Leg-kicking during sleep
- ❑ Leg cramps in sleep
- ❑ Trouble falling asleep at night
- ❑ Trouble staying awake at night
- ❑ Racing thoughts when trying to sleep
- ❑ Increased muscle tension when trying to sleep
- ❑ Fear of being unable to sleep
- ❑ Fear of being unable to fall back to sleep after awakening at night
- ❑ Laying in bed worrying when trying to sleep
- ❑ Waking too early in the morning
- ❑ Sleep talking
- ❑ Sweating a lot at night
- ❑ Waking up with heartburn
- ❑ Waking up with reflux
- ❑ Waking up to urinate
- ❑ Nightmares
- ❑ Teeth grinding during sleep
- ❑ Morning headaches
- ❑ Morning dry mouth
- ❑ Sleepwalking
- ❑ Sleep terrors
- ❑ Tongue biting in sleep
- ❑ Bedwetting
- ❑ Acting out dreams
- ❑ Feeling paralyzed when falling asleep or waking up
- ❑ Dreamlike images when falling asleep or waking up
- ❑ Sudden weakness when laughing
- ❑ Sudden weakness when afraid
- ❑ Uncontrollable daytime sleep attacks
- ❑ Falling asleep unexpectedly
- ❑ Falling asleep at work
- ❑ Falling asleep while driving
- ❑ Recent change in sleep schedule
- ❑ Shift work interfering with sleep
- ❑ I use sleeping pills to help me sleep
- ❑ I use alcohol to help me sleep
- ❑ Pain interfering with sleep
  where is the pain? _____

<u>List your current average for each category</u>

_____Hours worked per day
_____Days worked per week
_____Glasses of cola or other caffeinated beverages/day
_____Cups of regular coffee per day
_____Mixed drinks per day (1-2 oz. straight or mixed)
_____Days of vacation per year
_____Cups of tea per day
_____Cans of beer per day (12 oz.)
_____Glasses of wine per day (3-4 oz.)

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Sleep Disorders Questionnaire – Short Form

How long is your longest wake period at night?	❑Only a few minutes ❑30-60 minutes ❑Over an Hour
On average, how many times in a night do you get up to urinate?	❑None ❑1-2 times ❑More than twice
How many work accidents have you had as a result of sleepiness or fatigue?	❑None ❑Once ❑Several
Do you go to bed only when you are tired or do you go to bed because "it's time for bed"?	❑Time for bed ❑When tired
Which of these activities do you do after getting in bed?	❑Watch TV ❑Read ❑Eat snacks
If you are having difficulty falling asleep or wake up at night and can't get back to sleep, which of the following do you find yourself doing?	❑Clock watching ❑Staying in bed longer than 20 mins when you can't fall back asleep. ❑Getting frustrated ❑Worrying about being tired for following day ❑Worry about tasks which need to be completed
In the past two years, has your weight remained stable, increased, or decreased?	❑Remained Stable ❑Gained _____ pounds ❑Lost _____ pounds
If you snore, when did you start?	❑ within past year ❑1-5 years ago ❑5-10 years ago ❑since I can remember
Has your snoring become louder recently?	❑yes ❑no
Do you generally breathe through your mouth or nose during the day? How about when you're sleeping?	❑mouth ❑nose ❑mouth ❑nose
On a scale of 0-10, how loud is your snoring based on your own or your partner's observation, where ONE is quiet snoring and TEN being heard outside of your room.	0----------5----------10

Last Revised: 1/5/2010