TODD J. MALTESE, D.O.
MARYANA LIEDKE, D.O.

Neurology, EMG, NCV, EEG, TCD, Sleep Medicine

650 Hawkins Avenue
Suite 7
Ronkonkoma, NY 11779
Phone: 631-737-0055
Fax: 631-737-0076
www.mmneurology.com

WELCOME TO OUR PRACTICE! We look forward to meeting you during your first visit for your comprehensive sleep evaluation.

Please complete **ALL PAGES** in the attached new patient packet and bring it with you to your appointment.

- Please provide complete and accurate insurance information, and bring your insurance card and photo ID with you.
- If your insurance company requires a referral, please obtain one from your primary care physician (PCP) and bring it with you to your visit.
- If you have had any ***prior sleep evaluations or sleep studies***, please bring all written reports with you to your appointment.
- If you are transferring care from another physician, please obtain and bring your medical records and prior doctor's notes with you.
- **All copayments and/or outstanding balances are due IN FULL at the time of your visit.** We accept cash, checks, and all major credit cards. If you cannot pay your copay at the time of your visit, there will be a $15 administrative fee added onto your bill.
- **We appreciate 24-hour notice for cancellations.** If you do not provide notice of cancellation within 24 hours prior to your scheduled visit, you will be charged **$25** for an office visit or **$100** for a testing visit. Thank you for your cooperation in this matter.

Prescription Medication Policy:

- Schedule your follow-up appointments to coincide with renewal of your medications.
- Controlled substances CANNOT be refilled by telephone.
- Any changes to medications will require an office visit.

Thank you for allowing us to be involved in your medical needs, and we look forward to seeing you soon! If you have any questions, please do not hesitate to contact our office during our regular business hours.

Sincerely,

The Staff of Dr. Todd J. Maltese and Dr. Maryana Liedke

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Last Name: _____ **First Name:** _____

Date of birth: ____/____/____ ☐ **Male** ☐ **Female**

Age: _____ **Height:** _____ **Weight:** _____ **Collar size (men):** ____

Why are you having a sleep evaluation? What are your sleep problems?

_____

_____

_____

_____

Primary Care Physician:

Name: _____

Address: _____

Telephone number: _____ Fax number: _____

Referring Physician (if different from Primary Care):

Name: _____

Address: _____

Telephone number: _____ Fax number: _____

MEDICATIONS Please list all of the medications that you currently take.

Medication name	Dose	Times Per Day	Medication name	Dose	Times Per Day
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

*Please use the bottom of page 2 if you need more room to list your medications.

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ALLERGIES Are you allergic to any medications? ☐ Yes ☐ No
*If yes, please list the medication and your reaction to it.

Medication name	Reaction	Medication name	Reaction
1.		4.	
2.		5.	
3.		6.	

PAST MEDICAL HISTORY Have you ever been diagnosed with or treated for the following?

☐ High blood pressure	☐ Parkinson's disease	☐ Cervical disc herniations
☐ Diabetes	☐ Dementia	☐ Lumbar disc herniations
☐ High cholesterol	☐ Seizures	☐ Fibromyalgia
☐ Heart disease and/or stents	☐ Multiple Sclerosis	☐ Restless leg syndrome
☐ Cardiac arrhythmia and/or Afib	☐ Migraine headaches	☐ Depression
☐ Gastroesophagel reflux (GERD)	☐ COPD/Emphysema	☐ Anxiety
☐ Thyroid disease	☐ Neuropathy	☐ Attention deficit disorder
☐ Congestive Heart Failure	☐ Sleep apnea	☐ Substance abuse
☐ Stroke/TIA. Year? _____	☐ Cancer. What type(s)? _____	
Other medical problems:		

SURGICAL HISTORY

List all surgical procedures that you have had and their dates: _____

_____

_____

_____

_____

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SOCIAL HISTORY

Marital status: _____ Occupation: _____

Work status:

☐ Full time employment ☐ Retired ☐ Unemployed
☐ Part time employment ☐ Student ☐ Disabled

If no longer working, when was the last date that you worked? _____

Tobacco use:

☐ Never used tobacco products.
☐ Current smoker.
Average # of packs per day: _____ # of years smoking: _____
☐ Former smoker.
Quit date: _____ Average # of packs per day: _____ # of years smoked: _____

How often do you drink alcoholic beverages?

☐ Never ☐ Once or twice a week ☐ More than one drink per day
☐ Once or twice a month ☐ One drink per day ☐ Other: _____

How many caffeine-containing beverages do you consume in a typical day?

Coffee _____ Tea _____ Sodas _____

FAMILY HISTORY

Has anyone in your immediate family had the following medical conditions?

	Mother	Father	Siblings	Other
High blood pressure				
Heart disease/Heart attacks				
Diabetes				
High cholesterol				
Stroke/TIA				
Epilepsy/Seizures				
Parkinson's disease				
Dementia				
Sleep apnea				
Snoring				
Narcolepsy				
Depression/Anxiety				
Alcohol or substance abuse				
Other psychiatric illness				
Cancer/Tumors (what type?)				

Mother: ☐ Living (Year she was born: _____) ☐ Deceased (Age when passed away: _____)

Father: ☐ Living (Year he was born: _____) ☐ Deceased (Age when passed away: _____)

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SLEEP HABITS

What time do you usually go to bed on weekdays? ____:____ am / pm

How long does it take you to fall asleep? _____

What time do you usually awaken on weekdays? ____:____ am / pm

How many hours do you sleep per night? _____

What time do you typically go to bed on weekends/days off? ____:____ am / pm

How long does it take you to fall asleep? _____

What time do you awaken on weekends/days off? ____:____ am / pm

Do you take naps? ☐ Yes ☐ No

How many times per week? _____

How long are your naps? _____

Do you feel refreshed upon awakening from a nap? ☐ Yes ☐ No

How many times do you wake up in a typical night? _____

How long does it usually takes you to fall back to sleep? _____

What causes you to wake up (check all that apply)?

☐ Snoring	☐ Pain	☐ Bedroom noise
☐ Choking/gasping	☐ Hunger	☐ Bed partner/kids/pets
☐ Full bladder	☐ Thirst	☐ Worries

Have you had a sleep evaluation in the past? ☐ Yes ☐ No

If so, when? _____

What were the results? _____

Have you taken sleeping pills or sleep aids in the past? ☐ Yes ☐ No

If so, which pills? _____

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How often do you or others notice the following?

	Never or Rarely	Sometimes (once a week)	Often (2-4 times a week)	Almost Always
Have trouble falling asleep.				
Lie awake with intense thoughts.				
Have restlessness or discomfort in the legs.				
Wake up during the night.				
Snore heavily.				
Stop breathing when you sleep.				
Awaken choking or gasping.				
Grind your teeth while sleeping.				
Kick or jerk at night.				
Talk in your sleep.				
Sleep walk.				
Have nightmares.				
Act out your dreams.				
Awaken feeling tense.				
Feel rested in the morning.				
Use an alarm clock or wake up call to wake up.				
Wake up in the morning with a headache.				
Wake up in the morning with nasal/sinus congestion.				
Wake up in the morning with dry mouth.				
Wake up in the morning with sore throat.				
Wake up in the morning with bedding in a mess.				
Heard a voice or seen things like visions as you fall asleep or as you wake up.				
Felt paralyzed momentarily upon awakening or as you fall asleep.				
Have attacks of sudden physical weakness during intense emotions (laughing, crying, etc).				

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Epworth Sleepiness Scale

*How likely are you to **doze off or fall asleep** in the following situations (as opposed to just feeling tired)? This refers to how you would usually feel over the past few weeks. Even if you have not done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation:*

0	1	2	3
No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

1. Sitting and reading ..... _____
2. Watching TV ..... _____
3. Sitting inactive in a public place (e.g., theater or a meeting) ..... _____
4. As a passenger in a car for an hour without a break ..... _____
5. Lying down to rest in the afternoon when circumstances permit ..... _____
6. Sitting and talking to someone ..... _____
7. Sitting quietly after a lunch without alcohol ..... _____
8. In a car, while stopped for a few minutes in traffic ..... _____

SUM: _____ / 24

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Fatigue Severity Scale

*Below are a series of statements regarding **fatigue**. By fatigue we mean a **sense of tiredness, lack of energy, or total body give-out**. Please read each statement and choose a number from 1 to 7, where number 1 indicates that you completely disagree with the statement and number 7 means that you completely agree. Please answer these questions as they apply over the **last two weeks**:*

1	2	3	4	5	6	7
Completely Disagree						Completely Agree

1. Exercise brings on my fatigue ..... _____
2. I am easily fatigued ..... _____
3. Fatigue interferes with my physical functioning ..... _____
4. Fatigue causes frequent problems for me ..... _____
5. My fatigue prevents sustained physical functioning ..... _____
6. Fatigue interferes with carrying out certain duties and responsibilities .. _____
7. Fatigue is my most disabling symptom ..... _____
8. Fatigue is among my 3 most disabling symptoms ..... _____
9. Fatigue interferes with my work, family, or social life ..... _____
10. Fatigue makes other symptoms worse ..... _____

SUM: _____ / 70

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REVIEW OF SYSTEMS Check all boxes that apply to you ***at this time***:

GENERAL	GASTROINTESTINAL	MUSCULOSKELETAL
☐ Fever or chills	☐ Heartburn	☐ Joint pain
☐ Fatigue	☐ Nausea or vomiting	☐ Muscle pain
☐ Weight loss or gain	☐ Constipation	☐ Muscle cramps
☐ Weakness	☐ Diarrhea	☐ Muscle twitching
EYES	☐ Abdominal pain	**NEUROLOGIC**
☐ Blurry vision	**ENDOCRINE**	☐ Headaches
☐ Double vision	☐ Heat intolerance	☐ Numbness/tingling
EAR/NOSE/THROAT	☐ Cold intolerance	☐ Tremor
☐ Hearing loss	**BLOOD**	☐ Trouble with balance
☐ Congestion/Sinusitis	☐ Anemia	☐ Confusion
☐ Ringing in your ears	☐ Easy bruising/bleeding	☐ Dizziness/lightheadedness
CARDIOVASCULAR	**URINARY**	☐ Memory loss
☐ Chest pain	☐ Urinate frequently	☐ Difficulty swallowing
☐ Palpitations	☐ Urinary incontinence	☐ Speech difficulty
☐ Swelling of feet	**SKIN**	**PSYCHIATRIC**
RESPIRATORY	☐ Rashes	☐ Anxiety/nervousness
☐ Shortness of breath	☐ Dryness	☐ Depression
☐ Cough		☐ Hallucinations
☐ Wheezing		

DEMOGRAPHICS Please check all that apply.

Race: ☐ American Indian ☐ Asian ☐ Hawaiian or Pacific Islander
☐ Hispanic ☐ White ☐ Black or African American
☐ Other Race: _____ ☐ Refuse to Report

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse to Report

Language: ☐ English ☐ Spanish ☐ Other: _____

Registration Form (please print clearly) **Date:** _____

PATIENT INFORMATION

Patient Name: _____ E-mail Address: _____

Street Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Are you presently working: ☐ Yes ☐ No

Employer's Business Name: _____ Occupation: _____

Employer's Address: _____
(street address) (city) (state) (zip)

Employer's Phone Number: _____ Is this related to an accident? ☐ Yes ☐ No

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____
(street address) (city) (state) (zip)

PRIMARY INSURANCE INFORMATION

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____

Insured's Address (if different than patient): _____
(street address) (city) (state) (zip)

Insured's Social Security #: _____-_____-_____ Relationship to Patient: _____

Insured Employed By: _____ Address: _____

_____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____
(street address) (city) (state) (zip)

I.D. Number: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION (*if applicable*)

Secondary Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____
(street address) (city) (state) (zip)

I.D. Number: _____ Group Number: _____

Insured's Name (if different than above): _____ Insured's Date of Birth: _____/_____/_____

Insured's Address (if different than above): _____
(street address) (city) (state) (zip)

Insured's Social Security #: _____-_____-_____ Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____,
(name of insurance company)

and assign directly to Todd J. Maltese, DO, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____/_____/_____

Responsible Party Signature **Relationship** **Date**

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OFFICE POLICIES

Insurance/Referral Policy:

- It is the responsibility of the patient to ensure that his or her insurance information is up-to-date. If a claim is denied due to a change in insurance, and our office was not notified of this change prior to your office visit, you may be responsible for the cost of the entire medical bill. ALWAYS keep us updated with any changes in insurance.
- A copy of your valid insurance card must always be on file in our office.
- If your insurance company requires a referral, it is your responsibility to obtain one from your primary care physician (PCP) and bring it with you to your visit. You cannot be seen if you require a referral and you do not have one at the time of your visit.

Copay/Balance and Cancellation/No-Show Policy:

- All copayments and/or outstanding balances are due IN FULL at the time of your visit, or you might not be able to be seen. If you do not pay your copay at the time of your visit, there will be a $15 administrative fee added onto your bill.
- We appreciate 24-hour advanced notice for cancellations. If you do not provide notice of cancellation prior to your scheduled visit, you will be charged:

$25 for an office visit or **$100 for a testing visit**

Prescription Medication Policy:

- Schedule your follow-up appointments to coincide with renewal of your medications. Please note that if needed, renewing non-controlled medications by phone may take up to 3 business days to be processed, so please plan accordingly.
- Controlled substances CANNOT be refilled by telephone.
- Any changes to medications will require an office visit.

I have read and agree to the above office policies for the practice of Todd J. Maltese, D.O., P.C.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

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Health Insurance Portability and Accountability Act (HIPAA)

This consent is given to the office of Todd J. Maltese, DO, PC, to use and disclose my individually identifiable health information for the specific purposes of obtaining payment from my health plan, providing appropriate treatment, and performing permissible healthcare medical procedures.

These specific uses and disclosures are permitted under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide to such restrictions.

I have the right to revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I hereby grant permission that phone calls for the purpose of confirming or canceling appointments may be made to my home phone number, and messages may be left on answering machines.

My contact for emergencies is listed below. In addition, I ☐ DO ☐ DO <u>NOT</u> give you permission to speak with him/her in regards to my routine healthcare matters or concerns:

_____ _____

Name of emergency contact Phone Number

_____

Relationship

I consent to the above privacy practices of the office of Todd J. Maltese, D.O., P.C.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

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MEDICAL RECORDS RELEASE AUTHORIZATION

To: _____

_____

_____

Kindly release a copy of my medical records, lab reports, and/or diagnostic test results to Todd J. Maltese, D.O., P.C. I have been advised and I understand that my medical records and information are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I hereby authorize the release of the above requested medical records.

_____ _____

Signature Date

_____ _____

Print Name Date of Birth