



**TODD J. MALTESE, D.O.**  
**LAURA M. DAVIDS, M.D.**

*Neurology, PM&R, 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. Laura M. Davids

**TODD J. MALTESE, D.O., P.C.***Neurology, EMG, NCV, EEG, TCD, Sleep Medicine*

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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?**

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**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?

|                                                         |                                                      |                                                     |
|---------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Parkinson's disease         | <input type="checkbox"/> Cervical disc herniations  |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Dementia                    | <input type="checkbox"/> Lumbar disc herniations    |
| <input type="checkbox"/> High cholesterol               | <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Fibromyalgia               |
| <input type="checkbox"/> Heart disease and/or stents    | <input type="checkbox"/> Multiple Sclerosis          | <input type="checkbox"/> Restless leg syndrome      |
| <input type="checkbox"/> Cardiac arrhythmia and/or Afib | <input type="checkbox"/> Migraine headaches          | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> Gastroesophagel reflux (GERD)  | <input type="checkbox"/> COPD/Emphysema              | <input type="checkbox"/> Anxiety                    |
| <input type="checkbox"/> Thyroid disease                | <input type="checkbox"/> Neuropathy                  | <input type="checkbox"/> Attention deficit disorder |
| <input type="checkbox"/> Congestive Heart Failure       | <input type="checkbox"/> Sleep apnea                 | <input type="checkbox"/> Substance abuse            |
| <input type="checkbox"/> Stroke/TIA. Year? _____        | <input type="checkbox"/> 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                  |        |        |          |       |
| Obesity                     |        |        |          |       |
| Depression/Anxiety          |        |        |          |       |
| Alcohol or substance abuse  |        |        |          |       |
| Other psychiatric illness   |        |        |          |       |
| Cancer/Tumors (what type?)  |        |        |          |       |





**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)?

- |                                          |                                 |                                                |
|------------------------------------------|---------------------------------|------------------------------------------------|
| <input type="checkbox"/> Snoring         | <input type="checkbox"/> Pain   | <input type="checkbox"/> Bedroom noise         |
| <input type="checkbox"/> Choking/gasping | <input type="checkbox"/> Hunger | <input type="checkbox"/> Bed partner/kids/pets |
| <input type="checkbox"/> Full bladder    | <input type="checkbox"/> Thirst | <input type="checkbox"/> 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? \_\_\_\_\_



**How often do you or others notice the following?**

|                                                                                           | <b>Never or<br/>Rarely</b> | <b>Sometimes<br/>(once a<br/>week)</b> | <b>Often<br/>(2-4 times<br/>a week)</b> | <b>Almost<br/>Always</b> |
|-------------------------------------------------------------------------------------------|----------------------------|----------------------------------------|-----------------------------------------|--------------------------|
| 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). |                            |                                        |                                         |                          |



### 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:

| <b>0</b>               | <b>1</b>                   | <b>2</b>                     | <b>3</b>                 |
|------------------------|----------------------------|------------------------------|--------------------------|
| No chance<br>of dozing | Slight chance<br>of dozing | Moderate chance<br>of dozing | High chance<br>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





### 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<br>Disagree |   |   |   |   |   | Completely<br>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



**TODD J. MALTESE, D.O., P.C.***Neurology, EMG, NCV, EEG, TCD, Sleep Medicine***REVIEW OF SYSTEMS** Check all boxes that apply to you **at this time**:

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

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Patient Signature

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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 NOT 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 for 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