ACUTE ALTERNATIVE
MEDICAL GROUP & SLEEP CENTER

New Patient Demographics Form

Last Name _____ First Name _____ SS# _____-_____-_____ Sex: ☐M ☐F

Mailing Address_____

City _____ State_____ Zip _____ Birth Date _____/_____/_____
Month Day Year

Height: _____ Weight: _____

Home Phone: (___)_____ Mobile (___) _____ E-mail _____

Title: ☐Mr. ☐Ms. ☐Mrs. ☐Dr. Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow/Widower

Physical Address: _____

Work Phone_____ Ext. # _____ Employer/Occupation_____

Emergency Contact Full Name _____ Relationship _____

Phone (_____)_____ Mobile (_____)_____

Referred By: Dr. _____ Friend: _____ Patient: _____

Reason for Visit: _____

How long have you had this condition? _____

Are you under the care of a physician now? ☐Yes ☐No

If yes, for what reason(s)? _____

_____

Who is your physician? _____ Phone: (_____) _____

Other concurrent therapies_____

***Preferred Pharmacy:** _____

Child Responsible Party/ Subscriber Information

Full Name: _____ Relationship _____ D.O.B._____

Address: _____

Phone (___) _____ Mobile (___) _____ SSN _____

(PLEASE TURN OVER AND COMPLETE)

HEALTH INSURANCE INFORMATION:

Primary Insurance Company name: _____ Policy ID# _____

Subscriber Full Name: _____ D.O.B._____

Relationship: _____ Phone# **(_____)_____** **Mobile (_____)_____**

Address_____ City _____State_____, Zip _____

Secondary Insurance Company name: _____ Policy ID# _____

Subscriber Full Name: _____ D.O.B._____

Relationship: _____ Phone# **(_____)_____** **Mobile (_____)_____**

Address_____ City _____State_____, Zip _____

MEDICARE INFORMATION

Policy ID#_____

Subscriber name_____

Patient Payment Agreement for Services Rendered

I, _____, agree to all medical and professional services I receive from Acute Alternative Medical Group. I am responsible for any deductible and co-payment assigned by my health insurance. All other subsequent balance will be my full responsibility. I hereby authorize Lyn Campbell, M.D. and staff to render professional advice, medical treatment, and any procedures necessary and desirable by mutual agreement.

_____ **Date** _____

Patient / Responsible Party Signature

Self Pay Patients

I _____ am a self pay patient. I do not have medical insurance and I am responsible for the medical bills for services rendered.

_____ _____

Patient Signature **Date**

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Privacy Summary
9/01/11

Acute Alternative Medical Group (AAMG) is committed to preserving the privacy of your protected health information, in other words, information that can be used to identify you, such as your name, social security number, address, and telephone number. In fact, we are required by law to protect the privacy of your protected health information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

We are required by law to inform you how we use or disclose to other your protected health information for purposes of providing, coordinating or arranging for your care, consultation between providers, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your services. AAMG may not use or disclose any more of your protected health information than is necessary.

(We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization).

As someone we provide services to, you have important rights relating to **1)** inspecting and copying your protected health information that we maintain, **2)** amending or correcting that information, **3)** obtaining an accounting of our disclosures of your information, **4)** requesting that we communicate with you confidentially, **5)** requesting that we restrict certain uses and discloses of your information, and **6)** informing us if you think your rights have been violated.

We provide you a detailed Notice of Privacy Practices, which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top of this page indicates the date of the most current Notice in effect. You have the right to receive a copy of our most current Notice. If you have not yet received a copy of our current Notice and would like one, please ask and we will provide you with a copy. ☐ ***Verify receipt with initials***

If you have any questions, concerns or complaints about the Notice or you want more information please contact the Executive Assistant Eliza Combie at 184C Estate Diamond Ruby, Christiansted, VI 00820.

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996.

Name: _____ Date: _____

Signature: _____

Relationship to person: _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		**M F**		**Age**		**DOB:**	
Previous or referring doctor:		**Date of last physical exam:**					

ALLERGIES

Medications / Environmental

PERSONAL HEALTH HISTORY

☐	Abnormal Pap Smear	☐	Cancer or Tumor	☐	Heart Disease	☐	Seasonal / Environmental Allergies
☐	Alcohol /Substance Abuse	☐	COPD	☐	Hepatitis	☐	STD (Sexually Transmitted Diseases)
☐	ADD / ADHD	☐	Diabetes	☐	Herpes Simplex	☐	Stroke
☐	Arthritis	☐	Eczema or Psoriasis	☐	Hypertension	☐	Thyroid Disorder
☐	Asthma	☐	Headaches (Migraines)	☐	Neck Pain	☐	Tuberculosis
☐	Back Pain	☐	Gout	☐	Pneumonia	☐	Ulcers
☐	Bleeding Disorder	☐	Heart Attack	☐	Seizures	☐	None of The Above

Other:

Briefly give details of any of the conditions you have checked.

Please tell us if you have any conditions / Physical Restrictions or other health problems (including emotional and/or mental health) which require special arrangements.

FAMILY MEDICAL HISTORY

Please indicate if any blood relatives (parents, grandparents, siblings) have had any of the following:

☐ Asthma	☐ Bleeding Disorder	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ High Cholesterol	☐ Hypertension	☐ Intestinal Disorder	☐ Kidney Disorder	☐ Mental Illness
☐ Neurological	☐ Stroke	☐ Thyroid Disease		

☐ Other

SURGICAL HISTORY Please list the type(s) of surgeries, hospitalizations, or serious injuries you have had.			
☐ Appendicitis	☐ Cardiac Catheterization / Stents	☐ Open Heart / Bypass	☐ Thyroid Removal
☐ C-Section (Cesarean)	☐ Kidneys or Liver Implants	☐ Orthopedic Surgery	
☐ Gallbladder	☐ Hysterectomy	☐ Pacemaker	
☐ Other:			

IMMUNIZATIONS		
☐ Child (Up To Date)	☐ TB	☐ Polio (OPV, IPV)
☐ Hepatitis B (Series of 3)	☐ Hepatitis A (Series of 2	☐ Varicella (Chicken Pox)
☐ MMR (Measles, Mumps, Rubella)	☐ Meningitis	☐ Tetanus

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug	Strength	Frequency Taken

SOCIAL HISTORY	***(All questions contained in this questionnaire are optional and will be kept strictly confidential).***						
Caffeine:	None Coffee Tea Cola Num. of cups/cans per day?						
Alcohol:	Do You Drink Alcohol? Yes No					If yes, what kind? Beer Wine hard Liquor	
	For How Long? _____ How many drinks per week? _____						
Tobacco:	Do you smoke or use tobacco products?						Yes No
Drugs:	Do you currently use recreational or street drugs?						Yes No
	Have you ever given yourself street drugs with a needle?						Yes No
Marital Status:	Single	Married	Divorced	Separated	Widowed	Number of Children: _____	
Describe your regular physical activity or exercise program:							
Type: _____							
Intensity:	Minimal Moderate High		Days per week: _____			Duration: _____ Minutes	

I certify to the best of my knowledge this information is complete and accurate.

_____ Patient's (print) name

_____ Patient's signature

_____ Date

ACUTE ALTERNATIVE
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Sleep Center Screening and Order Form

Patient Name:_____ Date of Birth:_____

Phone Number:_____ Primary Care Physician:_____

We have developed this self-scoring questionnaire as a guide to help identify sleep disorder breathing problems. Please check [✓] the appropriate box if you have experience any of the symptom(s) on a regular basis. Your doctor will discuss these results with you during your follow up visit to his/her office.

1. I have been told I snore [ ]
2. I have been told that I stop breathing when I sleep, although I may have no recollection of this. [ ]
3. I am always sleepy during the day even when I have slept throughout the night. [ ]
4. I have high blood pressure. [ ]
5. I have been told that I sleep restlessly. I am always "tossing" and "turning" [ ]
6. I tend to sweat excessively during my sleep. [ ]
7. I frequently awaken with a headache in the morning. [ ]
8. I tend to fall asleep during inappropriate times. [ ]
9. Others and/or I have noticed a change in my personality. [ ]
10. I am overweight. Current weight: _____ Height:_____ [ ]

Total Checked [✓] Positive [ ]

SCORING : If you have **Marked 3 or More Boxes**, you show **Symptoms of Sleep Apnea**, a life threatening sleep disorder that causes you to stop breathing during your sleep.

Physician Sleep Prescription

<u>One Night Diagnostic Polysomnogram & one night CPAP titration (If AHI >15 on diagnostic study</u>

[ ] 95810 Initial
[ ] 95811 CPAP Titration
[ ] 95811 CPAP Re-Titration
[ ] G0399 Home Sleep Test

Diagnosis Codes:

[ ] G47.30 Sleep Apnea (Unspecified)
[ ] G47.33 Obstructive Sleep Apnea
[ ] G47.61 Periodic Leg Movements
[ ] R06.83 Snoring
[ ] R40.0 Daytime Sleepiness
[ ] G47.10 Hypersomnia
[ ] G47.41 Narcolepsy

Date:_____ Time:_____ Physician's Signature:_____