**Jeffrey R. Polito, M.D.**
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# PATIENT REGISTRATION (CONFIDENTIAL)

**DEMOGRAPHICS:**

Last Name: ________________________ First: ______________________ Preferred Name: __________________

Date of Birth: _________________ Gender (sex): ________________ Social Security #: __________________

Mailing Address: ______________________________________________________________________
*(Street Address)* *(City)* *(State)* *(ZIP)*

Permanent Address: ____________________________________________________________________
*(Street Address)* *(City)* *(State)* *(ZIP)*

Phone (√ Preferred #): Home: __________________ Work: __________________ Cell: ___________________

Email: _____________________________________ Preferred means of communication? Phone Email Text

**PERSONAL INFORMATION:**

Occupation: __________________________________________ Employer: ______________________________

Employer Address: ______________________________________________________________________
*(Street Address)* *(City)* *(State)* *(ZIP)*

Preferred Local Pharmacy: ______________________________ Location: _______________________________

Marital Status (select one): Single Married Separated Divorced Widowed Decline to answer

Race (select one): White/Caucasian Black/African American Hispanic/Latino Hawaiian/Pacific Islander
American Indian/Alaska Native Asian Other: _______________________ Decline to answer

**EMERGENCY CONTACT:**

Name: _________________________________ Relationship: ____________________ Date of Birth: ______________

Address: __________________________________________________________________________
*(Street Address)* *(City)* *(State)* *(ZIP)*

Phone #: Cell: _______________________ Home: ________________________ Work: _______________________

**INSURANCE:** ******Only Complete this section if you are NOT the Primary Policy Holder******

Primary Policy Holder: __________________________ Relationship: __________________ Date of Birth: ___________

Social Security #: __________________ Primary Phone: ___________________ Secondary Phone: _________________

# INSURANCE ACKNOWLEDGMENTS:

## Insurance Benefits & Payments:

I hereby authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Jeffrey R. Polito, M.D. I understand that regardless of insurance coverage and/or third-party involvement, I am ultimately financially responsible for charges incurred for care received from Jeffrey R. Polito, M.D. and his staff. I understand that it is my responsibility to provide current and correct insurance information and I am responsible for any charges that may result from incorrect or outdated information. If my insurance is an HMO, I understand that is my responsibility to ensure that I am assigned appropriately. I am responsible for any charges that I incur from any unassigned facilities or unauthorized physicians.

Signature: _______________________________________________ Date: ______________________

(Signature of patient or parent/guardian if minor)

## Insurance Changes:

There are many changes to health insurance policies both for patients and providers. Patients need to be sure to contact their carriers to fully understand their plan and their benefits. Any and all Co-pays are due at the time of service.

This office is currently participating in the Blue Shield "Covered California" plan. We are not contracted with the Blue Cross "Covered California" or "Pathway" plan. Your services may be applied to an "out of network" deductible. These plans tend to have high deductibles and you will be asked to take care of the allowed amount at the time of your visit.

For UC employees, it is our understanding that you may use your Tier 2 benefit in our office. We are not a part of the Tier 1 benefit, however, and you will have a deductible and a co-insurance amount with this coverage. UC Students with coverage through the university health plan must have a referral in hand from student health prior to services.

Medi-Cal and Cencal services are provided on a referral basis for sleep medicine conditions only. You must have a referral from your primary care physician. Other, Medical/Cencal/SBHI are not accepted as primary or secondary insurance.

By signing below, you acknowledge receipt and understanding of the above terms.

Signature: _______________________________________________ Date: ______________________

(Signature of patient or parent/guardian if minor)

## Understanding an HMO/POS:

When a patient belongs to an HMO/POS they are assigned to a specific group of physicians. You have chosen Jeffrey Polito, M.D. as your Primary Care Physician who contracted with two groups: **Santa Barbara Select IPA (SBSIPA)** and **Sansum Clinic**. Your insurance card should have your assigned group printed on your card. (if your card does not indicate your medical group and assigned provider, you will be asked to contact your insurance to obtain that information).

As the patient, it is ultimately your responsibility to know which group you are associated with and to make sure that you are sent to the appropriate facilities and specialists covered by your insurance. We will try our best to send you to the appropriate providers covered by your insurance, but we are not responsible for any discrepancies that may occur. You will be held responsible for payments not received due to such discrepancies.

By signing below, you acknowledge receipt and understanding of the above terms.

Signature: ______________________________________________ Date: ______________________

(Signature of patient or parent/guardian if minor)

**ACKNOWLEDGEMENTS (HIPAA PRIVACY PRACTICES & OFFICE POLICIES:**

**NOTICE OF PRIVACY PRACTICES:**

I acknowledge that I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Print Name: ____________________________ Signature: ____________________________ Date: ____________

*We attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:*

Individual refused to sign Communication barriers prohibiting obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgement Other: _______________________

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of CA, 800-633-3233, www.mbc.ca.gov

**MISSED APPOINTMENTS:**

**I understand that missed appointments or appointments cancelled less than 24 hours in advance WILL result in a $50 charge for office visits and a $500 charge for sleep studies. I agree to pay for these charges accordingly.**

Signature: _____________________________________________________ Date: ______________________

(Signature of patient or parent/guardian if minor)

**E-Prescribing PBM Consent:**

In the interest of improving quality of care, this office utilizes an electronic prescribing (e-prescribing) system to best send accurate prescriptions directly to pharmacies. The Medicare Modernization Act of 2003 lists standards that must be included as part of the e-prescribing program. These include *Formulary and Benefit Transactions* – giving prescribers information about which medications are covered under a particular benefits plan *& Medication History Transactions*- giving the provider access to information about medications the patient has been prescribed currently or previously by any provider in order to minimize the number of adverse drug events. This information is maintained by third party administrators know as Pharmacy Benefits Managers (PBM). PBM's primary responsibilities are processing and paying prescription drug claims as well as developing and maintaining prescription formularies for pharmacy benefits plans.

By signing below, you understand the office of Dr. Jeffrey R. Polito utilizes an e-prescribing system and agree that our office can request and use your prescription medication history from other healthcare providers and/or third party PBM payers for treatment purposes.

Signature: _____________________________________________________ Date: ______________________

(Signature of patient or parent/guardian if minor)

**PERMISSION:**

I give permission for Jeffrey R. Polito, M.D. and his staff to speak with the following people regarding my medical problems and/or diagnostic results related to my case. I have the right to revoke this consent in writing at any time.

Specified Individuals: 1. Name: _______________________________________ Relationship: _________________

2. Name: _______________________________________ Relationship: _________________

Signature: _____________________________________________________ Date: ______________________

(Signature of patient or parent/guardian if minor)

I give permission for the office to leave a message regarding my medical case on my personal voicemail:

YES _________ (initials) NO ________ (initials)

# SLEEP HISTORY & INTAKE

**PERSONAL INFORMATION:**

NAME: ______________________________ TODAY'S DATE: ____________________

DATE OF BIRTH: ______________ HEIGHT: _____ (feet/inches) WEIGHT: ___________ (pounds)

REFERRING PHYSICIAN: ____________________________ PHYSICIAN PHONE: __________________

PRIMARY CARE PHYSICIAN: _________________________ PHYSICIAN PHONE: __________________

BREIFLY DESCRIBE YOUR CHIEF COMPLAINT (REASON FOR YOUR VISIT):

______________________________________________________________________________

______________________________________________________________________________

**CURRENT MEDICATIONS:**

Are you currently taking any prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, "as needed" medications, etc.? Yes No List all medications below (Attach additional pages as needed)

| MEDICATION NAME: | DOSAGE: | INSTRUCTIONS (# TIMES PER DAY, ETC.) |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

**ALLERGIES:**

Any allergies to food, medications, environment, etc.? Yes No List below (attach additional pages as needed)

| MEDICATION/ALLERGEN: | REACTION: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

**PAST MEDICAL HISTORY:**

*Please list any medical conditions/issues that you have ever been diagnosed with (Attach additional page(s) as needed):*

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

7. ______________________________ 8. ______________________________

**PAST SURGICAL HISTORY:**

*Please list all surgeries that you have undergone and the year the procedure(s) were performed (Attach additional page(s) as needed):*

| SURGERY / PROCEDURE: | YEAR: | SURGERY / PROCEDURE: | YEAR: |
|---|---|---|---|
| 1. ____________ | ______ | 2. ____________ | ______ |
| 3. ____________ | ______ | 4. ____________ | ______ |
| 5. ____________ | ______ | 6. ____________ | ______ |

**PAST HOSPITALIZATIONS:**

*Please list any reasons for hospitalization(s) that you have ever had and the year (Attach additional page(s) as needed):*

| HOSPITALIZATION: | YEAR: | HOSPITALIZATION: | YEAR: |
|---|---|---|---|
| 1. ____________ | ______ | 2. ____________ | ______ |
| 3. ____________ | ______ | 4. ____________ | ______ |
| 5. ____________ | ______ | 6. ____________ | ______ |

**FAMILY HEALTH HISTORY:**

*Please answer the following questions about your immediate family (mother, father, siblings, aunts, and uncles):*

Have any of your family members been diagnosed or treated for the following:

Sleep Apnea: Yes No If yes, who? ______________________________

Narcolepsy: Yes No If yes, who? ______________________________

Restless leg syndrome: Yes No If yes, who? ______________________________

Is your mother still living? Yes No Current age (if living) or age passed away? ________

Is your father still living? Yes No Current age (if living) or age passed away? ________

Are there any significant illnesses/problems on your mother's side of the family? Yes No If yes, list them:

______________________________________________________________________

______________________________________________________________________

Are there any significant illnesses/problems on your father's side of the family? Yes No If yes, list them:

___________________________________________________________________________

___________________________________________________________________________

**SOCIAL HISTORY AND HABITS:**

Relationship status: Single Married (# years:______) Partnership (# years:______) Other: ____________

Occupation: ______________________________________________________________________

Do you currently smoke cigarettes? Yes No # of cigarettes/day: ________ # of years smoking: __________

Have you ever smoked cigarettes? Yes No # of cigarettes/day: ________ # of years smoking: __________

When did you quit smoking? ___________

Do you currently drink alcohol? Yes No If yes, how often? ___________( # of drinks per week)

Do you drink coffee, tea, soft drinks, or anything containing caffeine? Yes No # of cups per day: ____________

**SYSTEMS REVIEW:**

In the last 5 years, has your weight: Increased Decreased Stayed the same By how much? __________ lbs

Do you wake up wit dry mouth more than twice per week? Yes No

Do you have one or more headaches each week? Yes No If yes, are they worse in the morning? Yes No

Do you have heartburn one or more times per week or have a Hiatal Hernia/Reflux Disease? Yes No

Do you have sinus congestion one ore more times per week? Yes No

How many times do you wake up urinate during the night? 0 1 2 3 More than 3 times

Do you ever wake up in the night choking or gasping? Yes No

Have you ever had an overnight sleep study? Yes No

If yes, when? _______________ where? ___________________________ Results? ______________________________

Have you ever undergone surgery for snoring or Sleep Apnea? Yes No If yes, when? ____________________

Have you ever been diagnosed (or treated for) any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Hypertension (high blood pressure)? | Yes | No | Atrial Fibrillation (A.Fib)? | Yes | No |
| Coronary Artery Disease (blocked arteries)? | Yes | No | A stroke (TIA)? | Yes | No |
| Diabetes or Borderline Diabetes? | Yes | No | Depression? | Yes | No |
| Chronic Fatigue Syndrome? | Yes | No | Congestive Heart Failure? | Yes | No |
| Acromegaly? | Yes | No | Pulmonary Hypertension? | Yes | No |
| Chronic Pain Syndrome? | Yes | No | Fibromyalgia? | Yes | No |

**EPWORTH SLEEPINESS SCALE:**

*How likely are you to doze off in the following situations (in contrast to just feeling tired)? Even if you have not experienced some of these situations, try to imagine how these situations would affect you? Use the following scale:*

| | | |
|---|---|---|
| 0 | = | would never doze off |
| 1 | = | slight chance of dozing off |
| 2 | = | moderate chance of dozing off |
| 3 | = | high chance of dozing off |

| SITUATION: | CHANCE OF DOZING (0-3 SCALE): | | | |
|---|---|---|---|---|
| 1. Sitting and reading | 0 | 1 | 2 | 3 |
| 2. Watching TV | 0 | 1 | 2 | 3 |
| 3. Sitting, inactive in a public place (such as a theater or meeting)? | 0 | 1 | 2 | 3 |
| 4. As a passenger in a car for an hour without a break? | 0 | 1 | 2 | 3 |
| 5. Lying down to rest in the afternoon when circumstances permit? | 0 | 1 | 2 | 3 |
| 6. Sitting and talking to someone? | 0 | 1 | 2 | 3 |
| 7. Sitting quietly after lunch (without alcohol)? | 0 | 1 | 2 | 3 |
| 8. In a car, while stopped for a few minutes in traffic? | 0 | 1 | 2 | 3 |

**TOTAL** (Add up all the scores you have indicated above): ______________________

## FATIGUE SEVERITY SCALE:

*Rate the following on a scale of 1 to 7. A "1" meaning "completely disagree" and a "7" meaning "completely agree."*

| | DISAGREE (1) ← | | | | | | → AGREE(7) |
|---|---|---|---|---|---|---|---|
| 1. My motivation is lower when I am fatigued | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Exercise brings on my fatigue | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I am easily fatigued | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Fatigue interferes with my physical functioning | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Fatigue causes frequent problems for me | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. My fatigue prevents sustained physical function | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Fatigue interferes with carrying out my responsibilities | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Fatigue is among my three most disabling symptoms | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Fatigue interferes with my work, family and social life | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## SLEEP QUESTIONNAIRE:

### *SLEEP-WAKE SCHEDULE:*

What is your bedtime? ________________ Awakening time? __________________

Do you use an alarm clock? Yes No

Do you wake up during the night? Yes No

If yes, how many times per night? ______ For how long? ________

***DISTURBED SLEEP:***

Do you snore? Yes No

Have you lost your bed partner because of your snoring? Yes No

Have your breathing pauses been observed? Yes No

Have you ever been told that your limbs kick or twitch? Yes No

Do you talk in your sleep? Yes No

Do you walk in your sleep? Yes No

Do you act out vivid or violent dreams in your sleep? Yes No

***INSOMNIA:***

Do you have trouble falling asleep? Yes No

If, yes how long does it take you? ___________________ How many nights per week? ________________

If you wake up in the night, do you have trouble falling back asleep? Yes No

If yes, how long does it take you? ___________________ how many nights per week? _________________

Do you sleep better in an unfamiliar bedroom (such as a hotel room)? Yes No

Do you have an aching or squirmy sensation in your legs that stops you from sleeping? Yes No

Are you a light sleeper (easily awakened)? Yes No

***DAYTIME SLEEPINESS:***

Are you sleepy or tired all day? Yes No

Do you fall asleep watching TV or reading? Yes No

Have you ever fallen asleep at an inappropriate time (such as meetings, conversations, etc.)? Yes No

Have you ever had accidents or near-accidents because of sleepiness? Yes No

Have you ever "come to" or become alert suddenly and you were doing things without being aware of having started them or remembering how you got there? Yes No

Have you experienced sudden weakness in your body or legs while awake, perhaps after being startled or in an emotional situation? Yes No

Have you ever had hallucinations or dream like images while awake? Yes No

Have you ever had hallucinations or dream like images while asleep? Yes No

Do you take naps during the day? Yes No

If yes, how many days per week? _______ How long are the naps? _______

If yes, are your naps refreshing Yes No

If yes, do you dream during your naps? Yes No

Did you fall asleep, or often fight the urge to sleep in school as a child/adolescent? Yes No

***PAST SLEEP HISTORY:***

Did your current sleep problem begin in your childhood years? Yes No

Were you considered hyperactive or hyperkinetic as a child/teen (Attention Deficit Disorder)? Yes No

## QUESTIONNAIRE FOR YOUR SPOUSE, ROOMMATE OR BED PARTNER:

*This section is to be completed by your spouse, roommate or bed partner about YOU (NOT about their sleep habits).*

Does the he/she snore? Yes No

Does he/she stop breathing in their sleep? Yes No

Do his/her legs or body kick or twitch? Yes No

Does he/she grind their teeth at night? Yes No

Does he/she walk in their sleep? Yes No

Does he/she sit up in bed while not awake? Yes No

Does he/she become rigid or shake during sleep? Yes No

Does he/she rock or bang their head during sleep? Yes No

Other observations to note about the patient:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________