NAPS North Atlanta Pulmonary & Sleep Specialists

993 C Johnson Ferry Road, Suite 300
Atlanta, Georgia 30342
404-303-1700/ Fax: 404-252-9527

Robert J Albin, MD
David E Westerman, MD
Alex Hebert, NP-C

To our New Sleep Patient:

On behalf of North Atlanta Pulmonary & Sleep Specialists (NAPS), we welcome and thank you for choosing our practice. It is our desire to make your visit a pleasant one and to work with you to establish a positive treatment plan.

Please help us provide quality medical care by bringing the following items:

1. **All of your medications**. If you are unable to bring the medications, please bring a complete list, the dosage, and the number of times taken daily, including all over-the-counter medications.
2. **Previous Sleep Study records** (if you have had a previous sleep study).
3. **History and demographic forms** (enclosed or provided on our website).
4. **Insurance card**
5. **Government issued photo ID**
6. **Insurance Referral**, if a requirement of your insurance plan

If you have any questions or concerns prior to your appointment, please feel free to call our office at 404-303-1700 between the hours of 8:00 AM and 4:00 PM.

Thank you again for choosing North Atlanta Pulmonary & Sleep Specialists. We look forward to meeting you.

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993 C Johnson Ferry Road, Suite 300
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404-303-1700 or 404-250-4530 • Fax 404-252-8026

AUTHORIZATION TO RELEASE INFORMATION

Name: ______________________ DOB: __________ SSN: ______________

PLEASE SEND INFORMATION TO:

______________________ Attention: __________ Phone: ______________
Name of Provider/Clinic/Organization

______________________ Fax: ______________
Street Address

____
City, State, Zip Code

I AUTHORIZE the following information to be disclosed by: ______________________
(Please check all that apply)

_____ Entire Record
_____ The medical records concerning the time period of: ______________________.
_____ Operative/Procedure Notes
_____ Biopsy reports
_____ Labs
_____ Office notes
_____ Pathology reports
_____ CDs of Imaging studies (CT, PET, MRI)
_____ Imaging study reports (x-rays, etc.)

This information is requested for the purpose of: ______________________

____

ADDITIONAL PATIENT INFORMATION:

- **I understand that if the office has not received my records by the date of my appointment, my appointment can or may be rescheduled.**
- I understand that I do not have to sign this authorization to get treatment.
- I understand that this request can take up to five (5) business days to process.
- I understand that the medical records to be released may contain information related to HIV status, AIDS, alcohol or drug use, or mental health services and I hereby authorize release of this information.
  Please note: this authorization does NOT permit release of psychotherapy notes.
- I understand that under Georgia law OCGA 31-33-3, the party requesting the patient's records may be charged a reasonable cost for reproducing the requested records. Reasonable costs are determined by the Office of Planning and Budget for the State of Georgia.
- I understand this authorization for release of information is valid for a period of (1) year and may be withdrawn by me at any time except during an action taken in response thereon. I may revoke this authorization by submitting a written request to:

  ____
- I understand that there is a potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy regulations.

______________________ Date: ______________
Patient' Signature (Parent or Legal Representative, if applicable)

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize redisclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse, the following notice shall also apply.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFS Part 2). The Federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict the use of any of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

David Westerman, MD • Robert Albin, MD

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Please help us provide the best medical care to you by completing this form and listing the medications that you are currently taking and the medications you are allergic to, if any. Please complete this form and bring it to your appointment.

Patient's Name: ____ DOB: __________________

Please list the medications that you are currently taking: (include over-the-counter meds).

Medication Name:	Dosage amount:	Times taken per day:

Please list the medications that you are allergic to:

Thank you for your assistance in providing the above information.
Our goal is to provide you with the best medical care possible!

David Westerman, MD • Robert Albin, MD

#NAPS025
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NAPS North Atlanta Pulmonary & Sleep Specialists

Patient Account # ______________________________

Patient Name ____ Date of Birth: ________________

Patient email ____

Primary Phone Number ____________________ Cell Phone Number__________________________

Pharmacy Information:

Pharmacy Name ______________________________________

Pharmacy Address ____

Pharmacy Phone Number ______________________________

#NAPS006
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NORTHSIDE HOSPITAL
SLEEP DISORDERS CENTER

ADDRESSOGRAPH

AFFIX PATIENT LABELS OVER THIS BOX
BAR CODE MUST FALL BETWEEN THESE LINES

Patient Name: ____

Gender (circle one): Male Female Age: ____________

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

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

SITUATION	**CHANCE OF DOZING** (circle one)			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater or meeting).	0	1	2	3
As a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
Sitting and talking to someone.	0	1	2	3
Sitting quietly after lunch without alcohol.	0	1	2	3
In a car, while stopped for a few minutes in traffic.	0	1	2	3

TOTAL SCORE: __________ **AVERAGE AMOUNT OF SLEEP PER NIGHT:** __________

SIGN HERE: Completed by: ______________________ Date/Time: ______________________

Reviewed by: ______________________ Date/Time: ______________________

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EPWORTH SLEEPINESS SCALE

NH1663

NORTHSIDE HOSPITAL

SLEEP DISORDERS CENTER

ADDRESSOGRAPH

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INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE

While a thorough history will be verified when you arrive for your appointment, answering this questionnaire will assist in the diagnostic process. Please print, fill out and bring the completed form with you to your appointment.

GENERAL INFORMATION

Name: ______________________________

Date of Birth: ________ /________ /________ Age:____________ Marital Status: M ❑ S ❑ W ❑ D ❑

Address: ______________________________
Street Apt. #

____
City State Zip Code

Home #: ( ) ________________ Work #: ( ) ________________ Cell #: ( ) ________________

Height: __________ Weight: __________ Sex: M ❑ F ❑ Collar Size: _______

Occupation: ______________________ Years on Job: ____________ Shift: ________________

Referral Source: Physician ❒ TV ❒ Magazine ❒ Friend/Family ❒ Health Fair ❒ Other ❒______________

Name of Referring Physician: ______________________________

Phone #: ______________________________

Please state in your own words the reason (s) you or your doctor contacted the Sleep Disorders Center:

____

____

____

____

Have you been evaluated for this problem? Yes ❒ No ❒

Have you been treated for this problem? Yes ❒ No ❒ If yes, what treatments ______________________

Have you had a previous sleep study? Yes ❒ No ❒ If yes, when and where______________________

1. On average, how many hours of sleep do you get each night? _____hrs. _____min
2. How long does it usually take you to fall asleep? ____hrs. _____ min
3. Have anxiety (worry about things) while falling asleep? Yes ❒ No ❒
4. Feel unable to move upon awakening? Yes ❒ No ❒
5. Have creeping, crawling, aching or twitching feelings in your legs (feel like you have to move them)? Yes ❒ No ❒
6. Have vivid, dream-like scenes even though you know you are not totally asleep? Yes ❒ No ❒
7. Have any kind of pain or discomfort that interferes with sleep? Yes ❒ No ❒
   Please describe pain: ______________________________
   Location: ______________________________
   Intensity (0-10 scale): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
   Frequency (how often does it occur?): ______________________________
   What relieves it: ______________________________

SLEEP DISORDERS CENTER PATIENT QUESTIONNAIRE

8. Check one box for each statement - Do you:	Yes	No
a. sleep with someone else in your bed?	❐	❐
b. get up at night to attend to your children or something else?	❐	❐
c. been told you snore loudly?	❐	❐
d. feel your heart pounding during the night?	❐	❐
e. sweat a lot during the night?	❐	❐
f. walk in your sleep?	❐	❐
g. have unusual movements while asleep?	❐	❐
h. grind your teeth at night?	❐	❐
i. feel sleepy during the day?	❐	❐
j. fall asleep unintentionally? Please give an example: ________________________.	❐	❐
k. feel sad or depressed or anxious during the day?	❐	❐
l. feel weakness in your muscles when laughing, surprised, angry, excited, etc.?	❐	❐
m. take naps during the day?	❐	❐
n. travel frequently or do shift work?	❐	❐
o. choke, gasp or stop breathing during sleep or been told you do?	❐	❐

OTHER QUESTIONS

9. Does anyone in your family have a sleep problem? Yes ❐ No ❐

Relationship to You	Describe the problem
______________________________	______________________________
______________________________	______________________________

10. How much of the following fluids do you drink within 3 hours before bedtime?

a. Coffee: caffeinated	________	Cups
decaffeinated	________	Cups
b. Tea	________	Cups
c. Soda	________	Cans
d. Beer	________	Cans
e. Wine	________	Glasses
f. Other alcoholic beverages	________	Glasses

11. How much tobacco do you smoke during a 24-hour period? ______________________________

12. Please list the name and dose (in mg.) of all medications you take now or within the past 30 days:

Medication	Dose	What is it for?
a. ________________________	__________	________________________
b. ________________________	__________	________________________
c. ________________________	__________	________________________
d. ________________________	__________	________________________
e. ________________________	__________	________________________
f. ________________________	__________	________________________

13. Please list the name of any pill for sleeping or staying awake that you have taken in the **PAST:**

Name of Pill	**Did it Help?**
a. ____________________________	Yes ❐ No ❐
b. ____________________________	Yes ❐ No ❐
c. ____________________________	Yes ❐ No ❐
d. ____________________________	Yes ❐ No ❐

14. How many times each week do you participate in a sport or partake in some form of exercise ________________?

ADDRESSOGRAPH

NORTHSIDE HOSPITAL

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

HEALTH HISTORY

Please check any problem or illness you have now, or have had in the past:

- ❒ Heart Disease
- ❒ Low Blood Pressure
- ❒ Headaches
- ❒ Black Outs
- ❒ Hernia
- ❒ Back Trouble
- ❒ Asthma
- ❒ Cancer
- ❒ Eye Trouble
- ❒ Meningitis
- ❒ Depression
- ❒ Tuberculosis
- ❒ High Blood Pressure
- ❒ Fainting
- ❒ Ringing of the Ears
- ❒ Hemophilia (Bleeder)
- ❒ Prostate Trouble
- ❒ Gout
- ❒ Allergies
- ❒ Kidney Trouble
- ❒ Hearing Trouble
- ❒ Heartburn
- ❒ Venereal Disease
- ❒ Muscle Cramps
- ❒ Heart Attack
- ❒ Dizziness
- ❒ Epilepsy
- ❒ Ulcers
- ❒ Mental Problems
- ❒ Seizures
- ❒ Bronchitis
- ❒ Bladder Trouble
- ❒ Pneumonia
- ❒ Impotence
- ❒ Arthritis

SURGERIES & HOSPITALIZATIONS

Please list any hospitalizations and / or surgeries you have had. PLACE THE LATEST FIRST and include where, what, why, and when.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

15. Do you have any special needs (oxygen, wheelchair, visually/hearing impaired, etc.)?

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SLEEP DISORDERS CENTER PATIENT QUESTIONNAIRE

BED PARTNER QUESTIONNAIRE

Name of Patient: ____

Name of Person Filling Out This Form: ______________________________

Check any of the following behaviors that you have observed this person doing **while asleep**:

- ❒ Light Snoring
- ❒ Choking
- ❒ Grinding Teeth
- ❒ Bed Wetting
- ❒ Crying Out
- ❒ Awakening with Pain
- ❒ Becoming Very Rigid and/or Shaking
- ❒ Loud Snoring
- ❒ Pauses in Breathing
- ❒ Sleepwalking
- ❒ Biting Tongue
- ❒ Sitting Up in Bed Not Awake
- ❒ Head Rocking or Banging
- ❒ Apparently Sleeping Even if she/he Behaves Otherwise
- ❒ Occasional Loud Snorts
- ❒ Twitching or Kicking of Legs During Sleep
- ❒ Twitching or Jerking of Arms During Sleep
- ❒ Getting Out of Bed but Not Awake
- ❒ Mental Problems
- ❒ Seizures
- ❒ Bronchitis
- ❒ Other: ____

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

____

____

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____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations such as driving? ❑ Yes ❑ No

If yes, please explain: ____

____

____

____

____

____

____

____

____

____

Bed Partner Signature ______________________________ Date ______________

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404-303-1700 • Fax 404-252-9527
General Fax 404-236-8053

DIRECTIONS TO OFFICE:

<u>TRAVELING EAST ON 1-285:</u> EXIT 26 -Glenridge-Johnson Ferry.
Turn right and get in the left lane and come to the first stoplight. Turn left on Johnson Ferry Road. Go to the second light and turn right on Meridian Mark Road at the SunTrust Bank. Come to the first light and turn right. You will see the signs for Building C Parking. Building C is on your left as you drive in.

<u>TRAVELING WEST ON 1-285</u>: EXIT 28 Peachtree Dunwoody Rd.
Turn left onto Peachtree-Dunwoody Road. Come to the fourth light and turn right on Johnson Ferry Road. (You will see Northside Hospital on your right), come to the next light and turn left on Meridian Mark Road at the SunTrust Bank. Then turn right at first light, you will see signs to Building C Parking.

<u>TRAVELING SOUTH ON GA 400:</u> EXIT at the Glenridge Connector.
Proceed to the end of the ramp and tum right. Go to the second light and turn left onto Meridian Mark Road. Turn left at the first light into the Northside Hospital Professional Buildings. You will see the signs for Building C parking.

<u>TRAVELING NORTH ON GA 400:</u> EXIT at the Glenridge Connector.
Turn right off the exit ramp. At the first light, turn left onto Meridian Mark Road. Turn left at the first light into the Northside Hospital Professional Buildings. You will see the signs for Building C parking.