BOGAN SLEEP CONSULTANTS

1333 Taylor Street, Suite 6B
Columbia, SC 29201
803-251-3093 (P) 803-376-1876 (F)

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

Dr. Richard Bogan, MD Dr. William McLain, III Dr. Melissa Hummel Dr. Laura Herpel

Jo Anne Turner, ANP Hailey Atkinson, MSN, FNP-BC Stephanie Fournel, FNP

Thank you for choosing Bogan Sleep Consultants! We welcome you to our practice. You are scheduled for an initial consultation or a long-term follow up appointment with the provider indicated above.

Enclosed is the new patient packet. Please complete all forms and bring them with you to your appointment. It is important to complete the forms PRIOR to your appointment to avoid delays and to avoid being rescheduled. Along with your completed packet of information, please also bring your current insurance card(s), photo ID, and a list of current medications (including strength and dosage). Please include any sleep aides and/or allergy medications or other over the counter products.

If you are a former patient, and have not been seen in more than three years, you will need to complete new patient paperwork prior to being seen. It is important for us to have current information on file. If you have been seen recently, but have had a change of insurance or other demographic information, please contact our office and a member of our staff will be happy to update your patient record. If you have had a sleep study performed at another facility, please bring a copy of the results with you to your appointment.

Please be aware that all payments are due at the time of service. We accept cash, check, and all major credit cards. The appointment time listed above has been reserved for you. If you fail to cancel and do not show for your appointment, you will be charged a $30.00 No Show fee. If you have any questions, need to reschedule, or are running late, please call our office at 803-251-3093. We look forward to seeing you!

Sincerely,

The Staff of Bogan Sleep Consultants, LLC

Patient Name: _____ DOB: _____

OUR LOCATION:

Bogan Sleep Consultants, LLC
1333 Taylor Street, Suite 6B
Columbia, South Carolina

Enter the parking garage on Taylor Street across from the front entrance to Palmetto Baptist Medical Center.

FOR DAYTIME APPOINTMENTS:

Park in the garage on or near the sixth floor. Look for Bogan Sleep Consultants, Suite 6B, down the hallway across from the elevators.

FOR NIGHT-TIME SLEEP STUDIES:

Park on the first floor. The security guard will let you into the building. Take the elevator to the sixth floor. Look for Bogan Sleep Consultants, Suite 6B, down the hallway across from the elevators.

Please give at least 24 hours' notice if you need to reschedule your appointment.

OFFICE HOURS:	Monday through Thursday — 8:30AM to 5:00PM Friday - 8:30AM to 3:00PM
SLEEP LAB HOURS:	Sunday through Friday evenings — 7:00PM to 8:00AM
PHONE NUMBER:	(803)251-3093
FAX NUMBER:	(803)376-1876
WEBSITE:	www.BoganSleep.com

Please be advised that Bogan Sleep Consultants, LLC is a drug, alcohol, smoke, and weapon (concealed or open) free facility, Patients bringing any of these items to the sleep lab will be asked to secure the items in their vehicles or to reschedule the appointment.

IMPORTANT NOTICE - PLEASE READ

It is important to the integrity and accuracy of your sleep study that you avoid caffeine, chocolate, alcohol, and recreational drugs for at least 24 hours prior to your study. Daily medications should be discussed with your sleep specialist prior to your study, as certain medications may need to be discontinued for a specified length of time before your sleep study can be performed (at the discretion of your Bogan Sleep Consultants physician). Additionally, please avoid excessive lotions as well as hair extensions/weaves, as they can interfere with our ability to conduct the study, Failure to do so may result in rescheduling your study, we appreciate your full cooperation and look forward to providing you with the best possible care.

Patient Name: _____ DOB: _____

Patient Information

Name: _____ Date: _____
Last First Middle

SSN: _____ Gender ☐ M ☐ F Date of Birth: _____

Home Address: _____
Street City State ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Driver's License: _____
Number State

Race: (circle one)
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native Hawaiian or other Pacific Islander
- ☐ Other Race: _____

Ethnicity: (circle one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship to Patient: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

OTHER PHYSICIAN INFORMATION

Referring Physician Name: _____
Primary Care Physician (if different): _____
Other Physicians (if any): _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR

Parent or Guardian: _____
SSN: _____ Gender: ☐ M ☐ F Date of Birth: _____

Patient Name: _____ DOB: _____

Patient Financial Authorization and Release

Patient Information and Billing:

I understand and acknowledge that I am receiving healthcare services and that payment for services rendered on my behalf is my sole financial responsibility. I authorize Bogan Sleep Consultants, LLC to:

1. Bill my insurance provider and receive payment directly for all services rendered on my behalf.
2. Bill me for any balance not paid by my insurance carrier. This amount may include, but are not limited to, copayments, coinsurance, deductibles, and any other non-covered services. I acknowledge and understand that these charges are determined by my insurance provider and policy and agree to be financially responsible for all remaining balances.
3. Bill me directly for any services denied by insurance provider.

Accepting Assignment:

I acknowledge and understand that Bogan Sleep Consultants, LLC will accept assignment for all covered services provided, Assignment is defined as "Usual and Customary Charge" for covered services. These fees are established by the insurance carrier based on the geographical region in which the service is provided.

Liability Release:

I authorize full access to my insurance information and medical records necessary for billing the related charges for healthcare services provided to me. I authorize and give permission for Bogan Sleep Consultants, LLC to release any medical information or insurance information necessary to file any insurance claims, I release Bogan Sleep Consultants, LLC and its agents from any liability claims or damages that may arise from the disclosure of such information and quest for payment. I authorize and assign any benefits paid for me or my dependent to be paid directly to the provider. I understand and acknowledge that any balance remaining after insurance will be my sole responsibility. understand that a separate bill for interpretation may be sent from the interpreting physician.

I certify that I have read and understand the Patient Financial Authorization and Release and have access to a copy of this form.

Signature:_____ Date:_____

Printed Name:_____

If a representative is signing for the patient, please list relationship and print name below.

Relationship to Patient:_____

Printed Name:_____

Signature: _____

Patient Name: _____ DOB: _____

AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my protected health information. I understand that the information I authorize a person or entity to receive may be redisclosed and therefore no longer protected by federal privacy regulations.

Please choose the person/organization you are authorizing to receive protected health information:

Provider:_____

Spouse/Significant Other:_____

Other: _____

I understand that this authorization is voluntary and that I may refuse to sign this form. Unless otherwise protected by law, refusal to sign this form will not affect my eligibility for benefits, ability to obtain treatment, or receive payment.

I also understand and acknowledge that I may revoke this authorization at any time by notifying Bogan Sleep Consultants in writing. If I decide to revoke this authorization, the revocation date will be effective upon receipt of written notification and not retroactive to cover a period of time prior to the

date of written communication.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Patient/Guardian Date

Patient Name: _____ DOB: _____

Patient Medical History and Sleep Questionnaire

*Please complete all questions on this form PRIOR to your scheduled appointment so that your provider may conduct a comprehensive assessment at the time of your appointment. Failure to complete this information prior to your appointment, may result in a delay or you may be asked to reschedule.

Date: _____Patient Name: _____

Height: _____ Weight: _____

*Please tell us the reason you are here to be evaluated: _____

_____

Are you allergic to any medication? ☐ Yes ☐ No

If yes, please list: _____

Medications: please include all prescription and over the counter medications, including inhalers.			
Name	Strength/Dosage	Amount	Times Taken

Preferred Pharmacy: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Medications you have taken for sleep or to help with the wakefulness during the day.		

Patient Name: _____ DOB: _____

Past or Present Medical Disorders (please circle all that apply)

EYE, EAR, NOSE AND THROAT
- ☐ Glaucoma
- ☐ Seasonal/Environmental Allergies

LUNG/RESPIRATORY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Emphysema

GASTROINTESTINAL
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Ulcers (stomach)

HEMATOLOGY/ONCOLOGY
- ☐ Cancer: _____
- ☐ HIV
- ☐ AIDS
- ☐ Low Iron
- ☐ Vitamin Deficiency

GENITOURINARY
- ☐ Bladder/Urinary Incontinence
- ☐ Enlarged Prostate (BPH)
- ☐ Erectile Dysfunction (ED)

PSYCHIATRIC
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Alcohol Abuse/Dependence
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Personality Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Schizophrenia
- ☐ Substance Abuse/Dependence

CARDIOVASCULAR
- ☐ Atrial Fibrillation
- ☐ Other Rhythm Disorders _____
- ☐ Blocked Heart Arteries/Coronary Artery Disease (CAD)
- ☐ Blood Clot in Leg/Deep Vein Thrombosis (DVT)
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure/Hypertension
- ☐ High Cholesterol/High Lipids
- ☐ Heart Valve Disorder
- ☐ Pacemaker
- ☐ Pulmonary Embolism/Blood Clot in Lung
- ☐ Pulmonary Hypertension
- ☐ Tachycardia

ENDOCRINE
- ☐ Diabetes
- ☐ Low Thyroid
- ☐ High Thyroid
- ☐ Goiter

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis/Degenerative Joint Disease
- ☐ Lupus/Erythematosus Rheumatoid
- ☐ Arthritis

NEUROLOGIC
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Meningitis
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Seizures/Epilepsy
- ☐ Stroke

SLEEP
- ☐ Narcolepsy
- ☐ Obstructive Sleep Apnea
- ☐ Restless Legs Syndrome
- ☐ Insomnia

Patient Name: _____ DOB: _____

Surgical History

☐ Adenoids Removed/Adenoidectomy
Date Performed _____

☐ Appendix Removed/Appendectomy
Date Performed _____

☐ Gallbladder Removed/Cholecystectomy
Date Performed _____

☐ Tonsils Removed/Tonsillectomy
Date Performed _____

☐ Throat Surgery/UPPP
Date Performed _____

☐ Nasal/Sinus Surgery
Date Performed _____

☐ Oral Surgery
Date Performed _____

☐ Heart Surgery
Date Performed _____

Please list any other surgeries that you have had in the past that are not listed above:

_____

Social History/Habits

Disabled: ☐ Yes ☐ No If yes, type of disability: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other _____

☐ **If you are employed:**

What is your occupation? _____

How many hours do you work per week? _____

What shift do you work? ☐ day shift ☐ evening shift ☐ night shift ☐ swing shift

Tobacco Use:

Do you **currently** use tobacco products? ☐ Yes ☐ No

If yes, type: _____ Amount per day: _____ How many years: _____
If not currently, did you use tobacco products **in the past**? ☐ Yes ☐ No
If yes, type: _____ Amount per day: _____ How many years: _____

Alcohol Use: ☐ Yes ☐ No If yes, amount per day: _____

If not daily, how often: _____ Amount: _____

Caffeine Use: ☐ Yes ☐ No If yes, amount per day: _____

Recreational Drugs: ☐ Yes ☐ No If yes, which type: _____

Patient Name: _____ DOB: _____

Family History (Parents, Grandparents, etc.)

Does anyone in your family have **High Blood Pressure**?
☐ Yes ☐ NO If YES, which family member? _____
Does anyone in your family have **Diabetes Mellitus**?
☐ Yes ☐ NO If YES, which family member? _____
Does anyone in your family have **Heart Disease**?
☐ Yes ☐ NO If YES, which family member? _____.
Does anyone in your family have any **Respiratory/Breathing Disorders**?
☐ Yes ☐ NO If YES, which family member? _____
Does anyone in your family have a **sleep disorder**, use a device when sleeping or oxygen at night?
☐ Yes ☐ NO If YES, which family member? _____

	Living/Deceased	Age	Any Other General Health Issues (not listed above)
Father	_____	____	_____
Mother	_____	____	_____
Other			
_____	_____	____	_____

Review of Your Body Systems (Circle all that apply)

Constitutional
☐ Fatigue
☐ Weight gain in past 12 months: _____lbs.
☐ Weight loss in past 12 months: _____lbs.

Eye/Ear
☐ Blurred Vision
☐ Double Vision
☐ Hearing Loss
☐ Hearing Aids

Mouth/Nose/Throat
☐ Dentures
☐ Watery Nasal Discharge
☐ Sinus Pain
☐ Nasal Congestion

Cardiology
☐ Palpitations
☐ Leg swelling
☐ Chest Pain
☐ Shortness of Breath when lying down

Psychiatric
☐ Blue spells/depressed
☐ Mood swings
☐ Suicidal thoughts
☐ Feelings of hopelessness

Respiratory
☐ Chronic Cough
☐ Wheezing
☐ Shortness of Breath

Gastroenterology
☐ Heartburn
☐ Abdominal Pain
☐ Difficulty/Painful Swallowing
☐ Constipation
☐ Diarrhea

Musculoskeletal
☐ Joint Pain
☐ Leg Cramps
☐ Leg discomfort/pain
☐ Muscle Weakness

Neurology
☐ Frequent/Severe headaches
☐ Tremors
☐ Memory problems
☐ Unsteady Walking

Endocrine/Renal
☐ Urinary Frequency (More than 2x/night)
☐ History of Renal Disease
☐ History of Thyroid Disease

Patient Name: _____ DOB: _____

Your Sleep

Have you had a sleep study performed? ☐ YES ☐ NO
If YES, when? (Date): _____ Where? _____
Have you ever tried CPAP or BiPAP in the past? ☐ YES ☐ NO
Do you have a CPAP or BiPAP machine currently? ☐ YES ☐ NO
If YES, what company provided it? _____

Your main sleep problems include (check all that apply):

☐ Difficulty with going to sleep at night
☐ Waking up frequently during the night
☐ Unrested, no matter how much sleep you get
☐ Tiredness (not sleepiness) during the day
☐ Sleepiness during the day

Recent Sleep History:

Average time for "lights out" at home (when you plan to go to sleep): _____ ☐ AM ☐ PM
Average time to fall asleep _____ ☐ Minutes ☐ Hours
Average number of awakenings per night _____ times
Average time in bed _____ hours per night
Average total sleep time _____ hours per night
Average time for "lights on" at home (when you plan to get up) _____ ☐ AM ☐ PM
Does your bedtime vary more than one hour on weekends? ☐ Yes ☐ NO
How many times do you get out of bed to go to the bathroom/urinate? _____ times
Do you use sleep aids or medicines to fall asleep? ☐ YES ☐ NO
If YES, name of sleep aid(s): _____ Amount taken: _____
Do you have a regular bed partner? ☐ YES ☐ NO
Do you disturb your bed partner's sleep? ☐ YES ☐ NO
Do you take a nap during the day? ☐ YES ☐ NO
If YES, when do you nap and for how long? _____

When falling asleep or when you awaken at night do you OFTEN:

Watch TV, read, work on computer, or talk on the phone in bed? ☐ YES ☐ NO
Have anxiety or worry about things? ☐ YES ☐ NO
Have thoughts racing through your mind? ☐ YES ☐ NO
Worry about not being able to go to sleep ☐ YES ☐ NO
Feel sad or depressed? ☐ YES ☐ NO
Have pain or discomfort that effects sleep? ☐ YES ☐ NO
Easily awaken due to sounds or noise? ☐ YES ☐ NO
Have reflux (regurgitation or burning in throat)/heartburn? ☐ YES ☐ NO
Have a choking sensation? ☐ YES ☐ NO
Have chest pain or heart palpitations? ☐ YES ☐ NO

Patient Name: _____ DOB: _____

Your Sleep (Cont.)

Have nasal congestion? ☐ YES ☐ NO
Experience vivid, dreamlike scenes or hallucinations, even though you are awake? ☐ YES ☐ NO
Fell paralyzed or unable to move? ☐ YES ☐ NO
Have difficulty separating your dreams from reality? ☐ YES ☐ NO
Have restlessness or unable to keep legs still at night? ☐ YES ☐ NO
Do you have crawling, ache or unpleasant sensations in your legs at night? ☐ YES ☐ NO
If YES, is the feeling improved by moving your legs, i.e. walking or stretching? ☐ YES ☐ NO

During sleep do you OFTEN:

Snore? ☐ YES ☐ NO
Awaken gasping for air or feeling like you can't breathe? ☐ YES ☐ NO
Hold your breath or stop breathing during your sleep? ☐ YES ☐ NO
Sweat excessively? ☐ YES ☐ NO
Have vivid, colorful dreams? ☐ YES ☐ NO
Dream if you nap during the day? ☐ YES ☐ NO
Sleep Talk? ☐ YES ☐ NO
Sleep Walk? ☐ YES ☐ NO
Get up to eat? ☐ YES ☐ NO
Grind your teeth? ☐ YES ☐ NO
Have leg jerking or leg twitching? ☐ YES ☐ NO
Have bedwetting? ☐ YES ☐ NO

Your Daytime Functioning.

Do you OFTEN:

Wake up with a headache? ☐ YES ☐ NO
Experience episodes of muscle weakness, loss of muscle strength, or limp muscles in any part of your body during the following situations: laughing, angry, or telling a joke? ☐ YES ☐ NO

Do you:

Experience embarrassing situations due to sleepiness or tiredness? ☐ YES ☐ NO
Have uncontrollable urges to fall asleep during the day? ☐ YES ☐ NO

Have you:

Had accidents or near accidents while driving due to sleepiness? ☐ YES ☐ NO
Experienced work performance less proficient than desired due to sleepiness? ☐ YES ☐ NO

COMMENTS (Any other issues you believe affect your sleep or daytime functioning):

_____

_____

Patient Name: _____ DOB: _____

Preventative Care:

Have you had a Flu Shot (ages 50+ only)? ☐ YES ☐ NO

If YES, Approximately when?_____

Have you ever had a Pneumonia Vaccine (age 65+ only)? ☐ YES ☐ NO

If YES, Approximately when?_____

Have you had a Colonoscopy in the last 10 years (ages 50-75 only)? ☐ YES ☐ NO

If YES, Approximately when?_____

Insomnia Questionnaire

This is a test to assess, in general, how you are feeling about your sleep. Answer the questions rating how you feel about your sleep using a "0-4" point scale—with "0" representing no problem with your sleep and "4" representing a big problem with how you feel about the quality of your sleep.

Circle the answer that best describes your sleep.	No problem with my sleep	Slight problem with my sleep	Moderate problem with my sleep	Moderately severe problem with my sleep	Big problem with my sleep affecting all parts of my life
Overall, describe your satisfaction with your sleep?	●	**1**	**2**	**3**	**4**
How easy is it for you to fall asleep?	●	**1**	**2**	**3**	**4**
How worried are you that you won't be able to sleep?	●	**1**	**2**	**3**	**4**
Are you easily awakened by sounds and noises in the night?	●	**1**	**2**	**3**	**4**
When you sleep in a strange place or a bed other than your own, how much trouble do you have trying to fall asleep?	●	**1**	**2**	**3**	**4**
Is your sleep disturbed with frequent awakenings?	●	**1**	**2**	**3**	**4**
Can you fall back asleep if you awaken during the night?	●	**1**	**2**	**3**	**4**
Are you rested the next day after your night's sleep?	●	**1**	**2**	**3**	**4**
Do you think you are getting enough hours of sleep each night?	●	**1**	**2**	**3**	**4**
How much does the quality of the sleep affect your next day function (fatigue, mood)?	●	**1**	**2**	**3**	**4**

TOTAL SCORE (Add the circled numbers together): _____

Patient Name: _____ DOB: _____

Epworth Sleepiness Scale Bogan Sleep Consultants, LLC

Patient Name: _____ DOB: _____/_____/_____

Directions: Please read the list of situations and answer how likely you would be to doze off or fall asleep, but not just feel tired, at these times. This refers to the past three weeks. Even if you have not been in some of these situations, please try to guess how each would have affected you. Please choose the most appropriate answer from the choices provided.

Situation	Chance of Dozing
Sitting and reading	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
Watching television	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
Sitting quietly in a public place (ex. In a movie theater)	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
As a passenger in a car for an hour without a break	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
Lying down to rest in the afternoon	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
Sitting and talking with someone	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
Sitting quietly after a lunch without alcohol	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing
In a car, while stopped for a few minutes in traffic	❑ 0 Would never doze ❑ 1 Slight chance of dozing ❑ 2 Moderate chance of dozing ❑ 3 High chance of dozing

TOTAL SCORE: _____

Patient Name: _____ DOB: _____

Modified F.O.S.Q

Patient name: _____Date of Birth: _____Date: _____

Please assign each answer a score with the following answers:

1= Yes, Extreme 2= Yes, Moderate 3= Yes, A Little 4=No

QI. Do you have difficulty concentrating on the things you do because you are sleepy or tired? _____

Q2. Do you generally have difficulty remembering things because you are sleepy or tired? _____

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles)? _____

Q4. Do you have difficulty operating a motor vehicle for long distances (more than 100 miles)? _____

Q5, Do you have difficulty visiting family or friends in their home because you become sleepy or tired? _____

Q6. Has your relationship with family, friends, or work colleagues been affected because you are sleepy or tired?
_____

Q7. Do you have difficulty watching a movie or video because you are sleepy or tired?
_____

Q8. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired? _____

Q9. Do you have difficulty being as active in the evening as you want to be because you are sleepy or tired? _____

Q 10. Has your mood been affected because you are sleepy or tired? _____

TOTAL: _____