

Overlake Internal Medicine Associates
OVERLAKE SLEEP DISORDERS CENTER
1100 112th Avenue NE, Suite 320 Bellevue, WA 98004
Phone (425) 289-3000 Fax (425) 289-3240

Date _____

Dear _____,

Thank you for choosing Overlake Sleep Disorders Center for your care. We look forward to seeing you on _____, at _____ a.m/p.m.

Please complete the attached documents and bring them with you to your appointment. Directions to the Overlake Sleep Disorders Center are also attached.

Thank you,

Overlake Sleep Disorders Center Staff



Scott Bonvallet, M.D., FCCP Randip Singh, M.D. James O'Brien, M.D.

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24-HOUR CANCELLATION POLICY

Due to the nature of overnight sleep studies, it is necessary to make individual reservations for sleep studies. The following policy assures our ability to maintain availability of therapy, appropriate staffing, and timely service.

- ◆ For daytime appointments, please arrive fifteen minutes early to register and fill out paperwork.
- ◆ If you are more than 10 minutes late for any appointment, you may be asked to reschedule your appointment.
- ◆ If you must cancel or change your appointment for any reason, please do so at least **24-hours** in advance of your scheduled arrival time.
- ◆ For day time appointments, there will be a non-refundable **seventy five dollar (\$75.00)** charge for canceling an appointment less than 24 hours in advance or failing to show without notice.
- ◆ For overnight appointments, there will be a non-refundable **two hundred-fifty dollar (\$250.00)** charge if you miss your appointment without a **24-hour** notice.
- ◆ As a courtesy, we will attempt to confirm your appointment by telephone two to three days prior to your appointment. If we are unable to do so, please feel free to call to confirm your appointment at (425) 289-3000.

Please contact Overlake Sleep Disorders Center at (425) 289-3000 with any questions or concerns regarding appointments. Business hours are Monday – Friday, 8:00 a.m.-5:00 p.m.

Thank you for your cooperation,

Overlake Sleep Disorders Center



Scott Bonvallet, M.D., FCCP Randip Singh, M.D. James O'Brien, M.D.

Overlake Sleep Disorders Center

Account #: _____

Legal Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Sex: Male ___ Female ___ Social Security #: _____

Address: _____
(Street) (Apt./Unit#) (City) (State) (Zip)

Home Phone #: _____ Work Phone #: _____

Neck Size: _____ Are you a shift worker? Yes ___ No ___ Shift Hours: _____

Allergies: _____

Marital Status: _____ Name of Spouse: _____ Spouse's Contact Phone #: _____

Employer : _____

Address: _____
(Street) (Suite) (City) (State) (Zip)

Occupation: _____ Years @ your job: _____ If retired as of what date? _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone #: _____

Physician Information

Referral Source: Physician / Family / Friend / Other _____

Referring Physician: _____ / Phone#: _____

Regular / Primary Physician: _____ / Phone #: _____

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Birth date: _____

ID #: _____ Group #: _____

Your relation to Policy Holder: _____ Co-pay: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Birth date: _____

ID #: _____ Group #: _____

Your relation to Policy Holder: _____ Co-pay: _____

The above information is true to the best on my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made with this office, in advance. I authorize the physicians and Overlake Internal Medical Associates to release any information required to process my insurance claims. I also authorize payment of insurance benefits directly to Overlake Internal Medicine Associates.

Signature: _____ Date: _____

PATIENT NAME	DATE OF BIRTH	ACCOUNT NUMBER
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CONSENT TO CARE AND FINANCIAL RESPONSIBILITY

MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, the Sleep Center and its employees, and all other persons caring for me to provide treatment and care as may be deemed necessary and available to me during my stay in the Sleep Center including, but not limited to tests, examinations and medical treatment. I understand that my care is under the control of my attending physicians who are independent practitioners. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination at the Overlake Sleep Disorders Center.

PHOTOGRAPHS: The taking, reproduction and use of photographs in connection with my diagnosis, care and treatment at Overlake Sleep Disorders Center, for purposes of scientific and medical study and research is approved, provided my identity is not revealed. Photographs may include the use of video tapes and television.

OBSERVATIONS: For the purpose of advancing medical knowledge and training, I consent to the presence of observers during tests, examinations and other procedures.

RELEASE OF INFORMATION: I hereby authorize Overlake Sleep Disorders Center to disclose all or any part of my record, and any other information in the Center's possession, to any other person or entity which is or may be liable for all or part of the charges related to my care, including, but not limited to worker's compensation carriers, insurance companies, welfare funds, or my employer. I hereby release Overlake Sleep Disorders Center from all legal responsibility or liability, which may arise from disclosure of my record as provided in this paragraph. I hereby authorize Overlake Sleep Disorders Center to furnish requested information excerpts from my record to any insurer, its intermediary or another health care facility to provide continuity of care. Overlake Sleep Disorders Center may periodically participate in statistical research studies. I agree that statistical information can be released on an anonymous/confidential basis. I understand that Overlake Sleep Disorders Center keeps a record of the health care services provided and that I may request to review my record (a 24-hr notification is required). I may request a copy of all or any part of my record, (there is a charge for this service), and I may ask Overlake Sleep Disorders Center to correct that record. Except as noted above, Overlake Sleep Disorders Center will not disclose my record unless I direct them to do so, unless the law authorizes or compels them. I may see my records or get more information about it from the medical records department at Overlake Sleep Disorders Center.

I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION AND THAT I UNDERSTAND ITS CONTENT, MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature of patient (if not a minor) _____ Date _____ Time _____

The patient is unable to consent because _____

Signature of parent/guardian/other _____ Relationship _____ Date _____ Time _____

FINANCIAL AGREEMENT/PATIENT RESPONSIBILITIES:

You have the RESPONSIBILITY to:

- Provide accurate and complete details about your illness, hospitalization, medications and present conditions.
- Tell your doctor about any change in your condition or if problems arise.
- Tell your doctor or nurse if you do not understand your treatment or what you are expected to do.
- Accept financial responsibility for payment of services, pay your bill promptly or to inform OIMA Billing office if you are unable to pay your bill.
- Notify Overlake Sleep Disorders Center of any changes in healthcare benefits.

Initials _____ of Patient (if not a minor)

Initials _____ of Patient/Guardian or Other _____ Relationship _____

I UNDERSTAND THAT I CAN REQUEST A COPY OF OVERLAKE SLEEP DISORDERS CENTER'S NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES INFORMATION ABOUT HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED.

Initials _____ of Patient/Guardian * Initials imply full signature



Overlake Sleep Disorders Center



1100 – 112th Avenue NE, Suite 320
Bellevue, WA 98004
(425)-289-3000 Fax (425)-289-3240

Scott T. Bonvallet, M.D, FCCP
James K. O'Brien, M.D
Randip Singh, M.D.

Name: _____ MR#: _____

Primary Care Physician: _____ Referring Physician: _____

1. What are your primary concerns about your sleep? _____
2. Have you ever had a sleep study? _____ If yes (please bring a copy of the report with you), when and where was the study done and what were the results? _____

3. Any recent CT scans of your head or sinus? MRI of brain? Chest X-ray or relevant scan? _____
4. Any recent Echocardiogram or EKG? _____
5. Any recent lab work (electrolytes, thyroid, CBC, B₁₂, Iron)? _____
6. Please list any hospitalizations and/or surgeries that you have had. List the most *current* first.

7. Have you ever seen an ear nose & throat specialist, pulmonologist, neurologist, psychiatrist or allergist?

8. Please list any medication allergies you have:

HEALTH HISTORY

Please check any problems or illnesses that you have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcoholism/Drug abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anemia or iron deficiency | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia or pain syndrome | <input type="checkbox"/> Prostate Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headache | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Atrial fibrillation/Flutter | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Impotence / ↓ Libido | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cancer (What type?)_____ | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> ↑ Cholesterol | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression/Bipolar | <input type="checkbox"/> Muscle Cramps | |

9. Please list any medications you are currently taking including over the counter & herbal supplements:

Medication	Dose/Frequency	Medication	Dose/Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

DIET & EXERCISE		✓ YES
How many beverages containing caffeine or Taurine (i.e. Red Bull) average per day?		
Do you exercise or have you had a recent change in exercise habits?		
Any changes in your diet recently?		
Any weight fluctuations? If so, increase or decrease?		
NASAL / SINUS		✓ YES
Tonsillectomy and/or Adenoidectomy?		
Chronic Sinusitis or postnasal drip?		
Nasal polyps or congestion?		
History of nasal fracture?		
Use of intranasal steroidal sprays?		
Seasonal allergies (trees, grass, mold, dust, animal dander)?		
Use of decongestants or antihistamines?		
Surgical interventions for sleep problems/nasal problems or sinus problems? (i.e., UPPP, resection of turbinates, septoplasty)?		
Do you sleep with your mouth open?		
DAYTIME FUNCTIONING		✓ YES
Is your motivation level low?		
Are you easily distracted?		
Do you lose focus when listening or have difficulty concentrating when you read?		
Do you need instructions repeated or having difficulty tracking two things at once?		
Do you have difficulty finding words while talking or difficulty with mental arithmetic?		
Are you depressed?		
Are you irritable or would your significant other say that you are irritable?		
Are you impulsive or impatient?		
Do you have difficulty with your short-term memory?		

ENVIRONMENT

Please check any of the following that are in your sleeping environment:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Appliances (i.e.,
Washer/Dryer or
Dishwasher) | <input type="checkbox"/> Computer | <input type="checkbox"/> Other
_____ |
| <input type="checkbox"/> Bed partner | <input type="checkbox"/> Light | _____ |
| <input type="checkbox"/> Children | <input type="checkbox"/> Noise | _____ |
| | <input type="checkbox"/> Pets | _____ |
| | <input type="checkbox"/> Television | |

SLEEP HABITS

✓ YES

Have you ever taken any prescription or over the counter medication to help you sleep? If so, what have you taken?	
Is 8 hours of sleep necessary?	
Do you take naps?	
Do you read, watch television or use the computer before bed?	
Do you eat or snack prior to going to bed?	
Do you have racing thoughts while you are in bed?	
Have any of your medications changed the quality of your sleep?	
Do you currently or have you ever worked nights?	

SLEEP SCHEDULE

How long does it take you to fall asleep?	
What is your bedtime?	
How often do you wake up in the middle of the night?	
If you wake up from sleep, how long does it take you to fall back asleep usually?	
What time do you wake up in the morning?	
Do you take naps? If so, for how long?	
Do you sleep in on the weekend?	

BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Name of person completing this section: _____

I have observed this person's sleep: Never Once or Twice Often Every night

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

- | | |
|---|--|
| <input type="checkbox"/> Light Snoring
<input type="checkbox"/> Loud Snoring
<input type="checkbox"/> Head rocking or banging
<input type="checkbox"/> Choking
<input type="checkbox"/> Pauses in breathing
<input type="checkbox"/> Occasional loud snorts
<input type="checkbox"/> Getting out of bed but not awake
<input type="checkbox"/> Twitching or kicking of arms during sleep | <input type="checkbox"/> Twitching or kicking of legs during sleep
<input type="checkbox"/> Crying out
<input type="checkbox"/> Sitting up in bed not awake
<input type="checkbox"/> Biting tongue
<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Grinding Teeth
<input type="checkbox"/> Other
_____ |
|---|--|

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

If so, please explain _____

Additional comments _____

SLEEP RELATED PHENOMENA	✓ YES
Headache? If yes, have you experienced any: <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> changes in vision <input type="checkbox"/> rapid heartbeat <input type="checkbox"/> tearing or light sensitivity	
Witnessed apnea or pauses in breathing?	
Night sweats?	
Snoring? If yes, any changes in intensity or duration?	
Nodding off behind the wheel of a motor vehicle?	
Have you experienced choking, gasping arousals or snorting?	
Do you grind your teeth? If yes, do you wear a mouth guard?	
Do you have heartburn during the day or at night?	
While awake, have you had any shortness of breath when lying on your back?	
Have you ever been on a ventilator?	
Any swelling in your legs?	
Is your sleep worse before your menstrual cycle?	
Cyanosis in the morning (skin is blue)?	
Have you ever had the carbon monoxide levels checked in your home?	
Sleep walking, talking, eating; night terrors or waking up screaming?	
Do you act out your dreams (e.g. punching or kicking)?	
Coarse breathing or wheezing at night?	
Do you frequently wake up to urinate at night?	
Do your legs cramp at night?	
Do you feel discomfort in your legs? If yes: <input type="checkbox"/> Is it more noticeable at night? <input type="checkbox"/> Does it improve with movement?	
Have you ever felt weak during a bout of laughter?	
Have you ever woken up in the middle of a dream unable to move?	
Do you dream during naps?	

Epworth Sleepiness Scale:

What is your chance of dozing ? (On a scale of 0 to 3):

Sitting and reading: 0 1 2 3

Watching television: 0 1 2 3

Sitting inactive in a public place--for example, a theater, church or a 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: 0 1 2 3

Sitting and talking to someone: 0 1 2 3

Sitting quietly after lunch (when you've had no alcohol): 0 1 2 3

In a car while stopped in traffic: 0 1 2 3

Total Score:

Family Medical History:

Father: _____

Mother: _____

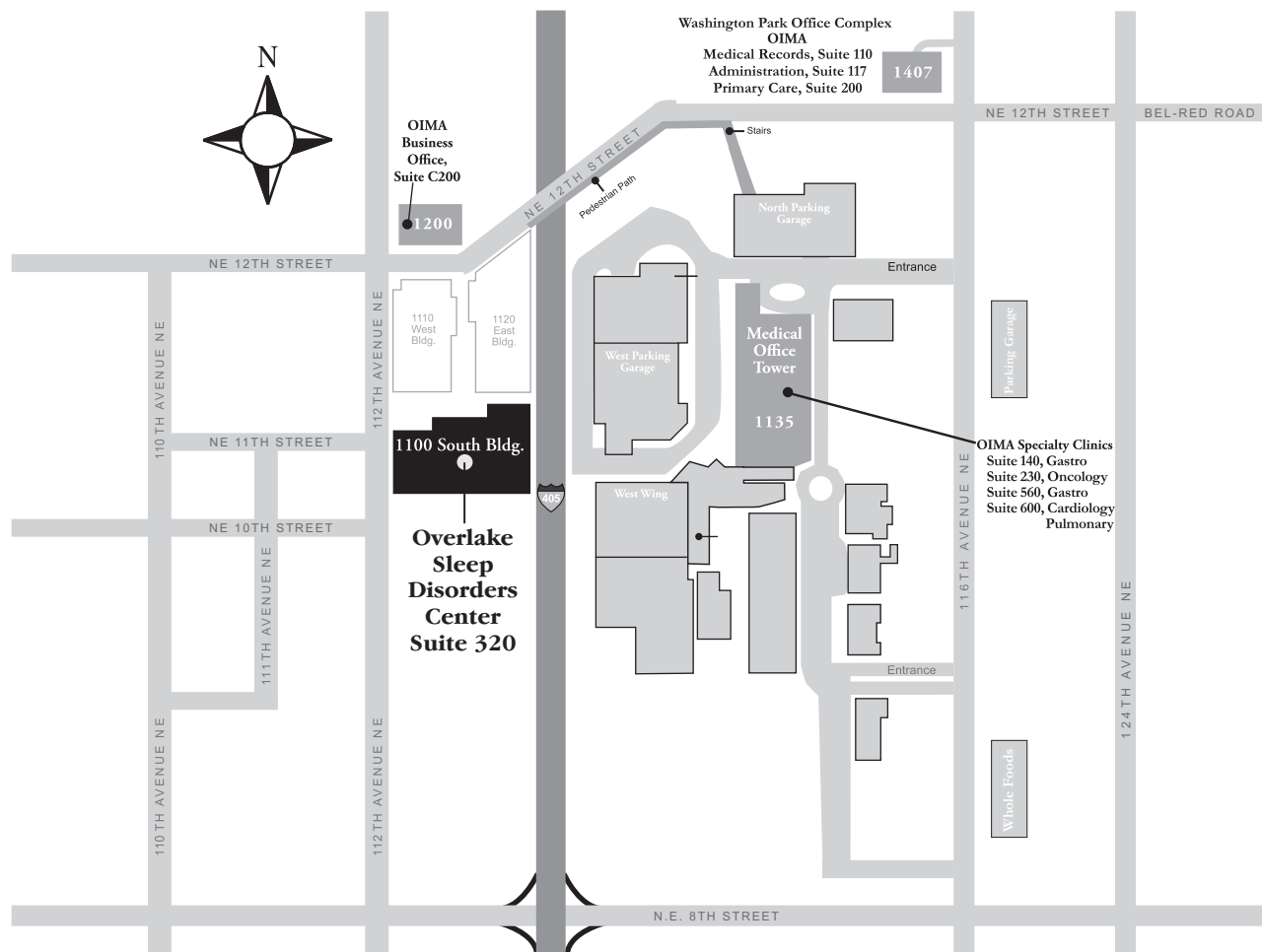
Social History:

Occupation: _____

How many alcoholic beverages do you average in a week? _____

Do you use tobacco? _____

Do you use any illicit drugs and if so which one(s)? _____



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DIRECTIONS from I-405 Southbound

- Take exit #13B - NE 8th Street **WEST** exit
- Stay in far right lane on exit ramp
- Make a sharp **right** onto 112th Avenue NE
- Following 112th Avenue NE **go through** the NE 10th street light
- Take next **right** into parking garage of 112th at 12th corporate center

DIRECTIONS from I-405 Northbound

- Take exit #13B - NE 8th Street **WEST** exit
- Continue through ramp to the “**WEST**” NE 8th street exit
- This ramp will put you onto NE 8th Street (heading west)
- Turn **right** onto 112th Avenue NE (the next light)
- Following 112th Avenue NE **go through** the NE 10th street light
- Take next **right** into parking garage of 112th at 12th corporate center

Proceed down the ramp into the parking garage and through the toll booth. Turn right after the toll booth, following the “Red” South Elevator signage to the **1100 South Bldg.** parking area. Take the “Red” elevator to the 3rd floor – suite 320.

OSDC does not validate parking. For your convenience, the parking garage does accept credit and debit cards. If you prefer to be dropped off at our front door, please enter from 112th Avenue and proceed up the ramp to the patient drop off and pick up location.