Last Name:____________________________

JOHN S. SUEN, M.D.
MICHAEL TONNER, M.D.
3735 11 Circle, Vero Beach FL 32960

Patient Information

PLEASE COMPLETE ALL LINES TODAY'S DATE: ________________

REFERRED BY: ____

PRIMARY CARE PHYSICIAN:____

Patient NAME: DR/MR/MRS/MS ____

Patient ADDRESS: ____

CITY: _________________________ STATE: _________ ZIP: ____________

HOME PHONE: _______________________ CELL: _______________________

WORK PHONE: _______________________ EMAIL: ______________________

SEX: F / M RACE: _____________________ OF HISPANIC ORIGIN: Y____ N____

DATE OF BIRTH: ____/____/____ SOCIAL SEC# _______-_______-________

EMPLOYER & ADDRESS: ____

____

PREFERRED LANGUAGE _________ MARITAL STATUS: M S D W

NAME OF SPOUSE: _______________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: ___________________________ PHONE: _______________________

INSURANCE INFORMATION: WE WILL NEED A COPY OF YOUR CARDS AND DRIVERS LICENSE. IF THE SUBSCRIBER ON THE INSURANCE IS DIFFERENT, PLEASE LIST NAME, DATE OF BIRTH, SOCIAL SECURITY # AND BILLING ADDRESS (PARENT, SPOUSE OR LEGAL GUARDIAN)

Name: _____________________________ PHONE: ______________________

ADDRESS: ____

DATE OF BIRTH: ____/____/____ SOCIAL SEC# _______-_______-________

WILL YOU BE PAYING BY ? CASH / CHECK / CREDIT CARD

Last Name:______________________________

Medication List: (Please include name, dosage, and directions)

1.___________________________ 11.___________________________

2.___________________________ 12.___________________________

3.___________________________ 13.___________________________

4.___________________________ 14.___________________________

5.___________________________ 15.___________________________

6.___________________________ 16.___________________________

7.___________________________ 17.___________________________

8.___________________________ 18.___________________________

9.___________________________ 19.___________________________

10.__________________________ 20. __________________________

Allergies and Allergic Reactions:

Allergy	Reaction
1.___________________________	1.___________________________
2.___________________________	2.___________________________
3.___________________________	3.___________________________
4.___________________________	4.___________________________
5.___________________________	5.___________________________
6.___________________________	6.___________________________
7.___________________________	7.___________________________
8.___________________________	8.___________________________
9.___________________________	9.___________________________
10.__________________________	10. __________________________

Last Name:_______________________________

Medical History Form: Please fill out as best you can. All information will become part of your confidential medical record.

MEDICAL HISTORY: Please list all of your known health problems

____

____

____

____

____

SURGICAL/HOSPITAL HISTORY: Please list all prior surgeries and major hospitalizations with date

____

____

____

____

____

____

FAMILY HISTORY:

Mother: Alive / Died Age _____ Problems:_______________________________

Father: Alive / Died Age _____ Problems:_______________________________

Siblings: Brothers (alive):____ Brothers (died):____ Sisters (alive):____ Sisters (died):____

Children: Sons : ____ Daughters : ____

Please list any health problems that your siblings and/or children have:

____

SOCIAL HISTORY: Do you smoke? Yes____ No ____ Former____ *(please fill in)* **____# packs per day for # _____ years**

Do you drink alcohol? No _____ Yes _____ *(If yes, how much do you drink?)*______

Have you used any medications or drugs not prescribed for you? _______________

Do you exercise on a regular basis? No _____ Yes _____

Occupation? *(if retired, what was your previous occupation)*_______________________

Last Name:______________________________

(WE ACCEPT MASTER CARD, VISA AND DISCOVER)

PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amount, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects.

Prescription drugs have potential for abuse and are regulated closely by state and federal agencies. Certain, more closely controlled drugs (*narcotic pain medications and tranquilizers*) require even more responsibility on your part. We will accept NO excuses for their loss, theft and will not order replacement. We expect you to notify our office if you change drug stores so that the order at the first store may be cancelled.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you will need a refill, please call our office with the name of you pharmacy and pharmacy phone number 24-48 hours prior so that we will have ample time to ask your treating physician and then call your medication in to your pharmacy. Please do not call the office again until we have been given the 24-48 hour time frame. Prescriptions will NOT be refilled after 12:00pm (noon) on Friday or on weekends.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR). If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

______________________________________ ____________________

Patient's Signature or Patient's Guardian Date

Pharmacy Name: ______________________________________

Pharmacy Phone:______________________________________

Last Name:______________________________

MEDICAL INFORMATION RELEASE FORM
(HIPPA RELEASE FORM)

Name: __________________________________ **Date of Birth:** _____/______/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Children ____

[ ] Other ____

[ ] Information is NOT to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:________________

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] ____

The best time to reach me is (day) ________________ between (time) ______________

Signed: _____________________________________ Date: _______________________

Witness: _____________________________________ Date: _______________________

Last Name:______________________

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I hereby authorize the release or use of my individually identifiable heath information (protected heath information) and medical record information by John S. Suen, M.D. or Michael Tonner, M.D. (the Practice) in order to carry out treatment, payment, or healthcare operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: noted on the previous page.

IN-NETWORK PAYMENT POLICIES

Dr. Suen and Dr. Tonner accept assignment on all Medicare patients. I understand that I am responsible for being aware of and meeting any deductibles. I understand that the 20% co-payment not covered by Medicare, or any co-payment not covered by private insurance, is expected on the day services are rendered. In case of financial hardship or difficulty, a financial arrangement must be made prior to initiation of treatment. Our office files your insurance as a courtesy twice. After the second try, the responsibility is yours,

Our office will file all the primary and secondary insurance claims for our patients. In most cases, we will receive payment from the insurance companies. However, in cases of the insurance company sending the payment to the patient, we expect the payment to be surrendered in its entirety. We ask that the patient endorse the check and forward to our office upon receipt as payment for services rendered by Dr. Suen and Dr. Tonner. By signing below you have indicated that you have read the aforementioned insurance disclosure and agree to comply with the policy set forth by our office.

If your Doctor is an IN-NETWORK provider for your insurance, YOUR CO-PAY MUST BE PAID AT THE TIME OF SERVICE AND ALL DEDUCTIBLES ARE DUE AT THE TIME OF THE VISIT.

Please note – Each insurance policy is different. It is **YOUR** responsibility to know your policy. If pre-authorization is needed, then it is **YOUR** responsibility to notify our staff so we may obtain authorization. If authorization is not obtained, it is **YOUR** responsibility to pay for all charges incurred. Remember, your insurance policy is a contract between you and your insurance company. It is NOT a contract between you and your doctor.

There is a $25.00 charge for NSF checks.

______________________ ______________________ __________

Signature **Printed Name** **Date**

Last Name:______________________________

John S. Suen, MD
Michael Tonner, MD

No Call/ No Show Policy

Your appointment is important to us and to your health. If you miss an appointment you may delay the treatment that you need. You may also have to wait longer than you would like for a new appointment date. We do not want to keep you waiting, but our health care providers are heavily booked and may not be able to reschedule you immediately.

If you must change your appointment, in consideration to others who are waiting to be seen here, please call is at least 24 hours in advance to cancel the appointment. You may leave a voice message. Failure to do so will result in a charge of $25 for office visits, $200 for sleep studies. This charge is not covered by insurance and is to be paid before another appointment can be scheduled.

We greatly appreciate your understanding and cooperation with this policy.

My signature below indicates that I have read and understand the above policy.

______________________________ ______________________________
Patient- Print Name Date of Birth

____
Patient Signature

SLEEP DISORDERS CENTER FLORIDA

3735 11th Circle, Suite 103, Vero Beach, FL 32960

PERMISSION TO PHOTOGRAPH AND/OR RECORD AUDIO AND VIDEO

I, ______________________________,
Patient/Guardian

hereby authorize Sleep Disorders Center Florida, or their representative, to take photograph(s) and/or record audio and video

of ______________________________.
Name of Patient

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. The sleep center and trustees of [insert corporation] and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to the [sleep center name] the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

☐ Check here if you do NOT authorize use for educational purposes.

____
Signature (patient or guardian)

____
Date

Relationship to Patient if Guardian ______________________________

____
Witness

____
Date

Sleep Disorders Center Florida

Patient Questionnaire

Name: ______________________________ **Date of Birth:** ___________

Height: _______ **Weight:** ________ **Neck size (inches):**_________

Referring Physician: ____________________ **Today's Date:** __________

Please check all that apply to you:

_______ Disturbed or restless sleep

_______ Frequent Unexplained Arousals

_______ Fragmented Sleep

_______ Non-Restorative Sleep (still feel tired upon waking after full night sleep)

_______ Excessive Daytime Sleepiness

_______ Fatigue

_______ Sleepiness interferes with social activities or work

_______ Disruptive/Loud Snoring

_______ Witnessed apneas during sleep (others witness you not breathing)

_______ Choking or gasping during sleep

_______ Speaking while sleeping

_______ Sleepwalking

_______ Snoring wakes you up

_______ Wake up and can't go back to sleep

_______ Unable to fall asleep/relax

_______ Experience dreaming shortly after falling asleep

_______ Sudden muscle loss or fainting feeling after experiencing strong emotions (laughing, crying, fear, anxiety, etc.)

_______ Fall asleep easily (in any situation)

_______ Fall asleep watching TV or reading

_______ Fall asleep having a conversation

_______ Experience leg pain, cramps, creeping/crawling/itching sensation in arms or legs when trying to fall asleep

_______ Experience twitching/movement of limbs while asleep (or partner complains of these)

_______ Awaken with heart pounding

_______ Awaken with sore/dry throat

_______ Other sleep complaints not listed:

____

____

____

____

Questionnaire Continued...

Have you ever had a sleep study? YES NO When? ______________________

Where? ____

Have you ever been on CPAP or BiPAP? Y N Do you use CPAP or BiPAP currently? Y N

CPAP or BiPAP Pressure (if known) __________

Why are you not using CPAP or BiPAP (if applicable)? ______________________

What is your preferred bedtime? __________ What time do you go to bed? __________

What time do you wake up? __________ How long does it take to fall asleep? __________

How many hours do you think you sleep at night? ______

How often do you use the restroom at night? ________times

Do you work shifts? YES NO If so, please explain: ______________________

Is your sleep different on weekends than weekdays? YES NO

If so, please explain: ______________________________________

Do you take naps during the day? YES NO How many? ______ How long each? ________

Do you take sleep aids? YES NO Name/dose______________________________

Where do you sleep? Traditional Bed Adjustable Bed Recliner

If using a recliner or adjustable bed, give reason why. ______________________

Do you require assistance getting in and out of bed? Y N

Do you have a caregiver to stay with you if you need assistance? Y N

Do you have any medical conditions that may affect your study or your ability to take a study that we need to be aware of? (i.e. tape or latex allergies, open wounds, recent surgery, acid reflux, etc.)

____

Do you have a pacemaker or internal defibrillator? Y N

Do you sleep with supplemental oxygen? Y N LPM: __________

Do you have any of the following medical conditions? (please check any and all that apply)

_____ Lung Disease _____ Heart Disease _____ Mental Disorders

_____ Depression _____ Drug addiction _____ Alcohol abuse

_____ Liver /kidney disease _____ Neurologic disorder _____ Diabetes

_____ Hypertension _____ Blood disorders _____ Chronic pain

_____ CHF (Congestive Heart Failure) _____ COPD (Coronary Obstructive Pulmonary Disorder)

_____ Asthma

The Epworth Sleepiness Scale

Name: ______________________________ Date of Birth: ____________

Height: ________ Weight: __________ Neck size (inches):________

Sex: Male Female (circle one) Today's Date: ____________

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 work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

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

Situation	*Chance of dozing*
Sitting and reading	____________
Watching TV	____________
Sitting inactive in a public place	____________
As a passenger in a car for an hour without a break	____________
Lying down in the afternoon when circumstances permit	____________
Sitting and talking to someone	____________
Sitting quietly after lunch without alcohol	____________
In a car, while stopped for a few minutes in traffic	____________
Total:	____________