The Children's Lung, Asthma & Sleep Specialists

2660 W. Fairbanks Avenue, Winter Park, FL 32789 - Phone 407-898-2767 - Fax 407-898-9443

www.childrensleeplab.com

Patient Name: _____ **DOB**: _____Age: _____ years / months

Nombre del Paciente: Fecha de Nacimiento: Edad: Anos/Messes

Primary Care/Referring Physician Name: _____

Dr. Primario/Dr. que los refirio**:**

Other Specialist or Physician Names: _____

Nombre de Otro especialista o Medico:

Please list any/all medications ***(including over the counter)*** that the patient is currently taking:

Porfavor nombre todas las medicinas que el paciente este tomando

_____

_____

Allergies *(Medication/food/environmental)*:_____

Alergias: (Medicina/Comida/Ambiental)

Has the patient had any allergy testing? ____YES ____NO If so, when: _____ how: Blood / Skin test

El paciente ha tenido examen de alergias? Si No Cuando: Como: Sangre/Examen de piel

Has your child had any X-rays/ CT scans or MRI's: ____YES ____NO If so, when: _____ Results: _____

Tu niño ha tenido algun rayo x/ CT Scan o MRI? Si No Cuando: Resultados:

Describe in your words the symptom(s) he/she is having:

Describe en tus propias palabras los sintomas que el paciente esta teniendo:

_____

_____

BIRTH HISTORY: Historia de nacimiento:

Birth weight: _____lbs _____oz. Length: _____in. Was the patient full term: ____YES ____NO

Peso de nacimeno: Medida El paciente estuvo en la barriga el tiempo entero? Si / No

If no, how early: _____ Vaginal or c-section:_____

Si no, cuan temprano nacio el paciente? Natural o cesarea:

PROBLEMS WITH PREGNANCY: Y___ N___ (if yes, please explain): _____

Algun problema con el embarazo? Porfavor explique si tuvo alguno:

FEEDING HISTORY: Historia de alimentación

Breast milk/ formula: _____ If formula, name and how long: _____

Leche de pecho/ Formula: Si fue formula, el nombre de la formula:

Solids were introduced at what age: _____ Current diet and food restrictions: _____

Comida Solida fue introducida a que edad? El paciente tiene alguna dieta o restriccion de comida?

Does the patient have any problems with coughing, gagging, or choking while eating: ____YES ____NO

El paciente tiene algun problema tosiendo, ahogandose, o asfixiandose cuando come? Si No

Does the patient have any problems with spitting up, vomiting, or stomach-aches: ____YES ____NO

El paciente tiene algun problema, escupiendo, vomitando, o dolores de estomago? Si No

GROWTH & DEVELOPMENT:

Has the patient ever had or currently has any of the growth/development issues including motor skills, sensory/communication, weight

or height: El paciente alguna vez tuvo o tiene actualmente alguno de los problemas de crecimiento / desarrollo, incluidas las habilidades motoras, sensoriales / de comunicación, peso o altura?

____YES ____NO

If so, please list: _____
Explique:

MEDICAL HISTORY:

Historia Medica:

Hospitalization(s): ____YES ____NO **Surgeries:** ____YES ____NO

Hospitalización? Si No Cirugias Si No

Please provide detailed information, such as dates and reasons:

Porfavor diganos informacion como dias o y/o motivos:

_____

_____

Has the patient ever had/ or currently has any issues listed below:

El paciente tuvo o actualmemte tiene algun problema de la lista aqui descrita:

Eyes ____YES ____NO Ojos	Throat ___YES ___NO Garganta	Joints/Bones ____YES ____NO Articulaciones / Huesos	Skin ____YES ____NO Piel
Ears ____YES ____NO Oidos	Heart ___YES ___NO Corazon	Bowel/Bladder ____YES ____NO Intestino / Vejiga	Seizures ____YES ____NO Convulsiones
Nose ____YES ____NO Naris	Kidney ___YES ___NO Riñones	Blood Pressure ____YES ____NO Presion de Sangre	Behavior ____YES ____NO Comportamiento

SLEEP HISTORY: HISTORIA DE DORMIR:

Does your child: Tu hijo:

: snore? ____YES ____NO If yes, nights per week:_____, How long: _____years/months
Ronca? Cuantas veces por semanas Por cuanto tiempo Años/Meses

: have difficulty falling asleep? ____YES ____NO
tiene dificultad para conseguir el sueño?

: wake up a lot at night? ____YES ____NO : sleep too much? ____YES ____NO
Se levanta mucho en la noche? Duerme Demasiado?

: appear restless while sleeping? ____YES ____NO : appear restless before sleeping? ____YES ____NO
parece inquieto mientras duerme? parece inquieto antes de dormir?

: fall asleep in school? ____YES ____NO : wake up screaming, crying or sleep walking? ____YES ____NO
Se queda dormido en la escuela? Se levanta gritando, llorando, o lo han visto caminando cuando duerme?

: have behavioral issues, learning problems or trouble with concentrating and focusing? ____YES ____NO
tiene problemas de comportamiento, problemas de aprendizaje o problemas para concentrarse y enfocarse?

What time does your child:
A que Hora su hijo/a:

Go to bed? _____ Go to sleep?_____Wake up (school days?)_____ (weekends?)_____
Se acuesta en la cama Se duerme Se levanta(Dias de escuela) (Fin de semana)

Does your child wake up in the middle of the night? ____YES ____NO
Su hijo/a se levanta en el medio de la noche? Si No

If so when and how often?_____
Cuan amenudo?

Any family history of sleep disorders? ____YES ____NO. If yes explain?_____
Alguna historia de desordenes de dormir en la familia? Explique

ASTHMA HISTORY: (complete this section only, if your child has been diagnosed with asthma, RAD or bronchitis)
HISTORIA DEL ASMA: (complete esta sección solamente, si su hijo ha sido diagnosticado con asma, RAD o bronquitis)

Has the child ever been diagnosed with asthma: ____YES ____NO If yes, at what age: _____
Alguna vez el niño ha sido diagnosticado con asma? Si No a que edad?

How many times has your child been hospitalized for asthma? _____ . Any ICU admissions/intubations? ____YES ____NO
Cuantas veces tu niño/a ha sido diagnosticado con asma? Cualquier admisión / intubación en la UCI Si No

How many times has your child been to ER for asthma over the last 12 months? _____
En los ultimos 12 meses cuantas veces el niño/a estado en la sala de emergencias por asma?

How many times has your child used an oral steroid (Orapred, prednisone) for asthma over the last 12 months? _____
Cuántas veces ha usado su niño un esteroide oral (Orapred, prednisone) para el asma en los últimos 12 meses?

Does your child have activity related shortness of breath, cough or wheezing?
Su hijo tiene dificultad para respirar relacionada con la actividad, tos o sibilancia?

Does your child cough at night or wakes up at night due to asthma? ____YES ____NO. If yes, how many nights a week? _____
Tose su niño de noche o se despierta por la noche debido al asma? Si No cuántas noches a la semana?

During the past two weeks how many times did the child use albuterol (to quickly relieve asthma symptoms)? _____
Durante las últimas dos semanas, ¿cuántas veces el niño usó albuterol (para aliviar rápidamente los síntomas del asma)?

IMMUNIZATIONS: INMUNIZACIONES:

Are immunization shots up to date:____YES ____NO TB test: ____YES ____NO PPD/Tine:____YES ____NO
Las vacunas están actualizadas? Si No Prueba de tuberculosis

Has the patient ever tested posted for TB or had a positive PPD reading: ____YES ____NO
Alguna vez el paciente ha realizado una prueba para tuberculosis o ha tenido una lectura positiva de PPD?

FAMILY HISTORY: Historia de familia:

Has/have any of your immediate family members been diagnosed with any of the following:
Alguno de los miembros de su familia inmediata ha sido diagnosticado con alguno de los siguientes

	Relation to pt: Relación con el Paciente		*Relation to pt*: Relación con el Paciente
Apnea	____YES ____NO_____	Asthma Asma	____YES ____NO_____
Bronchitis Bronquitis	____YES ____NO_____	Chronic Cough Tos crónica	____YES ____NO_____
SIDS/crib death Muerte de cuna	____YES ____NO_____	TB Tuberculosis	____YES ____NO_____
Cystic Fibrosis Fibrosis quística	____YES ____NO_____	Pneumonia Neumonía	____YES ____NO_____
Emphysema Enfisema	____YES ____NO_____	Hay Fever Fiebre de heno	____YES ____NO_____
Sickle Cell/Anemia Anemia falciforme	____YES ____NO_____	Sarcoidosis	____YES ____NO_____

ENVIRONMENTAL/SOCIAL: AMBIENTAL / SOCIAL:

Mother's Name: _____ Father's Name: _____
Nombre de la mama: Nombre del papa:

Do you reside in a house/apartment/mobile home/other: _____
Viven en una casa/apartamento/Casa movil/otra:
How many people live in the home: _____
Cuantas personas viven en el hogar:

Please list their names and their relationship to the patient:
Porfavor lista sus nombres y relacion a el paciente:

_____

_____

Does anyone smoke in the residence: ____YES ____NO
Alguin fuma en la residencia?

Do you have pets: ____YES ____NO Are pets allowed in patient's room: ____YES ____NO
Tienen animales: Animales entran a el cuarto de el paciente?

If so, what kind: _____
Que tipo de animal?

Is there a history of mold or exposure to mold in the household? ____YES ____NO

Existe historial de moho en el hogar?

Is there a history of exposure to mold at school? ____YES ____NO
Existe historial de exposición al moho en la escuela?

Residential Information: Informacion de la residencia:

A) How old is the residence: _____
Cuan vieja es la residencia:

B) How long have you lived there: _____
Por cuanto tiempo llevan viviendo alli:

C) What type of heat/cooling system does it have: _____
Que tipo de aire tienen en la casa: (central/ unidad de ventana)

D) Any fans (both ceiling and/or portable): ____YES ____NO How many: _____
Tienen ventiladores? (De techo o portable?) Cuantos?

E) How much dust accumulates: ____Minimal ____Moderate ____Heavy
Cuanto polvo se acumula en su hogar? Minimal Mas o menos Mucho

F) Please list all flooring you have(i.e. tile, wood, laminate, carpet): _____
Que tipo de piso tienen (Loseta, Madera, lamiado, alfombra)

G) Is there carpet in the bedrooms:____YES ____NO
Tienen alfombra en los cuartos?

H) Does the patient:_____Have his/her Own Room ____ Share a Room
El paciente: Tiene su propio cuarto Comparte el cuarto

I) Are there stuffed animals/ pillows in the patient's room: ____YES ____NO
Tienen peluches en el cuarto?

School & Sports Information**: **Informacion de Escuela & Deportes:

A) Does the patient attend: ____School ____Daycare ____Before/After School Care
El paciente asiste Escuela guardería Antes / Después cuido de la escuela

B) What grade is the patient in: _____
En que grado esta el paciente

C) How many days have been missed due to illnesses this year: _____
Cuantos dias a faltado el paciente a la escuela este año por estar enfermo

D) Presently how would you rate their performance in school: ____Poor ____Average ____Above Average
Cómo calificaría su desempeño en la escuela? Mal Mas o menos Bien

E) How often does the patient have gym class: _____
Cuantas veces a la semana el paciente tiene educacion fisica

F) Does the patient play any sports: ____YES ____NO
El paciente juega algun deporte? Si No

G) How does he/she interact & get along with other children: ____Poor ____Average ____Above Average
Como el/ella interactua con otros niños? Mal Mas o menos Bien

H) Does the patient make friends easily: ____YES ____NO
Se le hace facil a el paciente hacer amigos?

_____ _____
Print name and relationship to patient Date
Imprimir el nombre y la relación con el paciente Fecha

_____ _____
Signature of Parent/Guardian Date
Firma de Padres o guardian Fecha

Children's Lung, Asthma & Sleep Specialists
Main Office: 2660 W. Fairbanks Avenue, Winter Park, FL 32789
Phone: 407-898-2767 - Fax: 407-898-9443 - Toll Free 866-383-0556 - Toll Free Fax 877-898-9443
Akinyemi Ajayi, MD, FCCP, D-ABSM, FAASM
Seifu Demissie, MD **– Khalid Ahmad**, MD

Please provide us your pharmacy information.

Patient's Name:_____

nombre del paciente

Patient's Date of Birth:_____

fecha de nacimiento del paciente

Parent's Email:_____

E-mail de los padres

Pharmacy Name:_____

nombre de la farmacia

Pharmacy Address:_____

dirección de la farmacia

Pharmacy Phone Number:_____

número de teléfono de la farmacia

I acknowledge to have read and understand the Children's Lung, Asthma & Sleep Specialists policies.
Reconozco haber leído y comprender las políticas de los especialistas en pulmones, asma y sueño de niños.

_____ _____
Parent Signature / firma de los padres Date / fecha

_____ _____
Patient's Name / Nombre de los pacientes DOB / fecha de cumpleaños

The Children's Lung, Asthma & Sleep Specialists
The Children's Sleep Laboratory

2660 W. Fairbanks Avenue, Winter Park, FL 32789 - Phone 407-898-2767 - Fax 407-898-9443
www.childrensleeplab.com

Patient Information

Date/Fecha: _____

Name / Nombre _____ Sex / Sexo **M or F** DOB / Fecha de nac _____

Social Security # / Numero Social _____ Phone / Telefono _____ Cell: _____

Address / Direccion _____ City / Ciudad _____ Zip / Codigo Postal _____

PCP / Medico de cabezera _____ Phone/Fax / Telefono y fax _____ Referred by PCP? / Fue referido por doctor primario yes☐ no ☐

Referring Physician / Medico que lo referio _____ Phone/Fax / Telefono y fax _____

Guarantor/Legal Guardian Information

Name / Nombre _____ DOB / Fecha de nac _____ SSN / Numero Social _____ Relationship / Relacion al paciente _____

Medical Insurance Information/Informacion del seguro

Primary Insurance / Seguro Primario _____ Phone/Telefono _____

Primary ID#: _____ Group #/Groupo _____

Secondary Insurance / Seguro Secundario _____ Secondary ID# _____

Failure to provide complete insurance information may result in patient responsibility for the entire bill.

Person to Contact In Case of Emergency/Contacto de Emergencia Besides Parents

Name(s) / Nombre _____ Relationship / Relacion al Paciente _____

Telephone #'s / Telefono _____

We participate in most insurance plans, and as a courtesy our practice will file your claims. However, some procedures (such as Pulmonary Function Test and Allergy Tests) are billed separately along with the office visit. In which, could be subject to your deductible and co-insurance that will be your responsibility. We *will not be responsible* for how your insurance carrier processes your claim so please ensure that you are fully aware of your individual plan requirements, limitations and benefits.

X_____
GUARANTOR

Participamos con la mayoría de las compañías de seguro medico, y como una cortesía nuestra practica le someterá su reclamación a su seguro. Sin embargo, algunos procedimientos (como Función Pulmonar y Pruebas de alergia) son cobrados por separado, junto con la vista medica. Estos procedimientos podrían ser sujetos a deducible y co-aseguranza, y esto será su responsabilidad. No nos hacemos responsables de como su seguro procese las reclamaciones, por lo tanto por favor asegúrese de conocer los requisitos, limitaciones y beneficios de su seguro medico.

X_____
FIRMA DEL PADRE O CUSTODIAL

EMAIL ADDRESS: _____ Correo electronico

PHARMACY INFORMATION: _____ Farmacia

I _____ACKNOWLEDGE THAT I HAVE RECEIVED AND READ THE PRACTICE FINANCIAL AND OFFICE POLICIES

X_____.

HIPAA ACKNOWLEDGEMENT: Our notice of privacy practices provides information about how we use and release protected health information about you. You have the right to review our notice before signing the form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front office staff. You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and release of protected health information about you for treatment, payment and healthcare operations as described in our notice. You have the right to revoke this consent in writing except where we have already made releases in reliance on your prior consent.

MAINTENANCE OF ELECTRONIC RECORDS AND SIGNATURES: Children's Lung, Asthma & Sleep Specialists maintains all its medical records and patient information in an electronic database. If you do not understand the above statements please ask staff to explain prior to your approval. Please note that this document will be scanned and included in the medical records.

TEXT / EMAIL / MAIL/ VOICEMAIL: Children's Lung, Asthma & Sleep Specialists will occasionally utilize these forms of communication for the purpose of appointment reminders and/or other correspondence. By signing below you are approving this form of communication. If you do not wish to consent to this, please cross through this area and initial next to it so that we are aware you are declining consent.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: It is our company policy to file your claim with your insurance company however, any account balances due to co-pays, coinsurances or deductibles are your responsibility. In the event that we are not contracted or if your insurance company, through no fault of ours, refuses to pay our contracted or billed fees then you will be fully responsible. All payments are due within 15 business days of the date printed on your statement, if not paid within the allotted timeframe you *may* incur a finance charge.

COMMERCIAL INSURANCE CARRIERS: CANCELLATION AND NO SHOW FEES/NOTICE: Failure to cancel an office visit/appointment within 24 hours will result in a **$50.00** No Show/Late Cancellation Charge being assessed to your account that is your responsibility. Failure to cancel a scheduled sleep study appointment within 24 hours will result in a **$250** No Show/Late Cancellation Charge being assessed to your account that is your responsibility. **MEDICAID AND ITS HMO'S**: Failure to cancel an office visit/appointment within 24 hours will result in possible **discharge** from our practice.

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS: Our office maintains the right to use your medical records/information for the purpose of treatment, payment and healthcare operation as deemed necessary. Records will be sent to other physicians directly involved in the care of the patient when appropriate. Sleep psychology/behavioral medicine records generated during new patient medical consultations and/or follow-up sleep or pulmonary visits will be sent directly to the referring physician and the primary care physician. If there are any individuals, or entities that you specifically DO NOT want to have access to this information please inform us.

I hereby assign all medical benefits to which I am entitled, including Private Insurance, Medicare and Medicaid in addition to any other health insurance plans to *Children's Lung, Asthma & Sleep Specialists/Orlando Pediatric Pulmonary & Sleep Associates*. A photocopy of this assignment is to be considered as valid as the original document.

By signing below I acknowledge that I have read, understand and agree to abide with the above statements, including acknowledging that I am *fully* responsible for any monetary debts due on this account. My signature represents that I am voluntarily entering into a legal and binding contract for services with *Children's Lung, Asthma & Sleep Specialists/Orlando Pediatric Pulmonary & Sleep Associates*.

By signing below I am acknowledging and consenting to the assessment and treatment by *Children's Children's Lung, Asthma & Sleep Specialists/Orlando Pediatric Pulmonary & Sleep Associates* providers which may include *Akinyemi Ajayi, MD, D,ABSM; Shivani Verma, MD; Kevin Kuriakose, MD; Seifu Demissie, MD; Shilpa Pandey, MD; Kimberly Hartzell, MD; Michael Light, MD; Vanessa Maenle, CPNP, MSN; Mary Alice Leinbach, DNP, CPNP, APRN; Bonnye Albert, APRN and/or Kimberly K. Justice, PhD, Psychologist,* for either myself and/or my minor child.

_____ _____

Printed Patient Name/
Nombre del paciente

Signature of Patient **(If not a minor)**
Firma del Paciente (Si no es un menor)

_____ _____

Printed Name of Legal Guardian
Imprimir nombre del Guardián Legal

Signature of Legal Guardian
Firma del Guardián Legal

_____

Date Signed/ Fecha de la firma