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

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

Primary Care/Referring Physician Name: _____

Other Specialist or Physician Names: _____

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

_____

_____

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

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

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

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

_____

_____

BIRTH HISTORY:

Birth weight: _____lbs _____oz. Length: _____in. Was the patient full term: _____YES _____NO

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

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

FEEDING HISTORY:

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

Current diet and food restrictions: _____

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

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

GROWTH & DEVELOPMENT:

Has the patient ever had/do they currently have any of the growth/development issues listed below: ____YES ____NO

A) Motor skills (i.e. crawling, walking, running, playing): ____YES ____NO
   If so, please list: _____
B) Sensory/communication (i.e. vision, hearing, speech): ____YES ____NO
   If so, please list: _____
C) Weight or height: ____YES ____NO
   If so, please list: _____

MEDICAL HISTORY:

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

Please provide detailed information, such as dates and reasons:

_____

_____

SLEEP HISTORY:

Does your child:

: snore? ____YES ____NO If yes, nights per week:_____, How long: _____years/months
: have difficulty falling asleep? ____YES ____NO
: wake up a lot at night? ____YES ____NO : sleep too much? ____YES ____NO
: appear restless while sleeping? ____YES ____NO : appear restless before sleeping? ____YES ____NO
: fall asleep in school? ____YES ____NO : wake up screaming, crying or sleep walking? ____YES ____NO
: have behavioral issues, learning problems or trouble with concentrating and focusing? ____YES ____NO

What time does your child:

Go to bed? _____ Go to sleep?_____ Wake up (school days?)_____ (weekends?)_____

Does your child wake up in the middle of the night? ____YES ____NO

If so when and how often?_____

Any family history of sleep disorders? ____YES ____NO

If yes explain?_____

Has the patient ever had/do they currently have any issues listed below:

Eyes	____YES ____NO	Ears	____YES ____NO	Nose	____YES ____NO
Throat	____YES ____NO	Kidney	____YES ____NO	Joints/Bones	____YES ____NO
Seizures	____YES ____NO	Behavior	____YES ____NO	Skin	____YES ____NO
Bowel/Bladder	____YES ____NO	Heart	____YES ____NO	Blood Pressure	____YES ____NO

IMMUNIZATIONS:

Are immunization shots up to date:____ YES ____ NO TB test: ____ YES ____ NO PPD/Tine:____ YES ____ NO
Has the patient ever tested posted for TB or had a positive PPD reading: ____YES ____NO

FAMILY HISTORY:

Has/have any of your immediate family members been diagnosed with any of the following:

		Relation to pt:			*Relation to pt*:
Apnea	____YES ____NO	_____	Asthma	____YES ____NO	_____
Bronchitis	____YES ____NO	_____	Chronic Cough	____YES ____NO	_____
SIDS/crib death	____YES ____NO	_____	TB	____YES ____NO	_____
Cystic Fibrosis	____YES ____NO	_____	Pneumonia	____YES ____NO	_____
Emphysema	____YES ____NO	_____	Hay Fever	____YES ____NO	_____
Sickle Cell/Anemia	____YES ____NO	_____	Sarcoidosis	____YES ____NO	_____

ENVIRONMENTAL/SOCIAL:

Mother's Name: _____ Father's Name: _____

Do you reside in a house/apartment/mobile home/other: _____
How many people live in the home: _____
Are there sibling(s) who attend school or daycare: ____YES ____NO.
Please list their age and their relationship to the patient:
_____
_____

Does anyone smoke in the residence: ____YES ____NO
Do you have pets: ____YES ____NO Are pets allowed in patient's room: ____YES ____NO
If so, what kind: _____

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

Is there a history of exposure to mold at school? ____YES ____NO

Residential Information:

A) How old is the residence: _____
B) How long have you lived there: _____
C) What type of heat/cooling system does it have: _____
D) Any fans (both ceiling and/or portable): ____YES ____NO How many: _____
E) How much dust accumulates: ____Minimal ____Moderate ____Heavy
F) Please list all flooring you have(i.e. tile, wood, laminate, carpet): _____
G) Is there carpet in the bedrooms:____YES ____NO
H) Does the patient:_____Have his/her Own Room ____ Share a Room
I) Are there stuffed animals/ pillows in the patient's room: ____YES ____NO

School & Sports Information:

A) Does the patient attend: ____School ____Daycare ____Before/After School Care
B) What grade is the patient in: _____
C) How many days have been missed due to illnesses this year: _____
D) Presently how would you rate their performance in school: ____Poor ____Average ____Above Average
E) How often does the patient have gym class: _____
F) Does the patient play any sports: ____YES ____NO
G) How does he/she interact & get along with other children: ____Poor ____Average ____Above Average
H) Does the patient make friends easily: ____YES ____NO

_____ _____
Print name and relationship to patient Date

_____ _____
Signature of Parent/Guardian Date

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Akinyemi Ajayi, MD, FCCP, D-ABSM, FAASM
Seifu Demissie, MD – **Khalid Ahmad**, MD

Please provide us your pharmacy information.

Patient's Name:_____

Patient's Date of Birth:_____

Parent's Email:_____

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone Number:_____

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I acknowledge to have read and understand the Children's Lung, Asthma & Sleep Specialists policies.

_____ _____
Parent Signature Date

_____ _____
Patient's Name DOB