

POLK STARLIGHT SLEEP LABS

Sleep Apnea and Sleep Disorder Diagnostic and Treatment Labs

INSTRUCTIONS TO PREPARE FOR YOUR SLEEP STUDY

SLEEP STUDY DATE: _____ **TIME: 9:15 P.M.**

This packet contains Sleep instructions, a map, and a questionnaire. The questionnaire is lengthy but it is important that you complete it as best you can. There will be questions that may not pertain to you; if so please write N/A, or leave it blank and proceed to the next question.

ADDRESS: 3003 S FLORIDA AVENUE SUITE 203, LAKELAND, FL 33803
DIRECTIONS: Side streets are Carey Place and Young Place. Park in the back in the back of the building near the double glass doors. Please arrive promptly at 9:15 pm and wait in your vehicle. The technician will come downstairs between 9:00 pm-9:15 pm to bring patients upstairs. You will be finished with your study at 5:30 am the next morning.

We will call you the day before to remind you of your appointment. If you need to cancel or reschedule for any reason, it is important that you call our office. **WE CHARGE A \$100 CANCELLATION FEE IF 24 HOUR NOTIFICATION IS NOT GIVEN. IF YOU ARE SCHEDULED ON A SATURDAY OR SUNDAY, NOTIFICATION MUST BE GIVEN NO LATER THAN THE THURSDAY PRIOR TO YOUR APPOINTMENT.** Please give as much advanced notice as possible; we have a list of patients looking forward to moving their appointment date up on as ASAP list.

If you are sick the day of the study, please call and reschedule.

Do not stop any medications unless instructed to do so by your physician.

No caffeine or alcohol after 2:00 pm, and **NO** naps on the day of the study.

Please make sure you have a shower and you come with clean, dry hair. **NO** hair creams, lotions, moisturizers, or rinses.

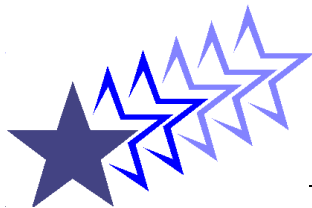
Males: Please shave if you are normally clean shaven.

Bring something comfortable to sleep in. Pajamas, sweats, shorts, t-shirt, etc. Women should preferably wear two pieces rather than a nightgown.

If you currently use a C-PAP/BI-PAP machine, please bring the mask with you.

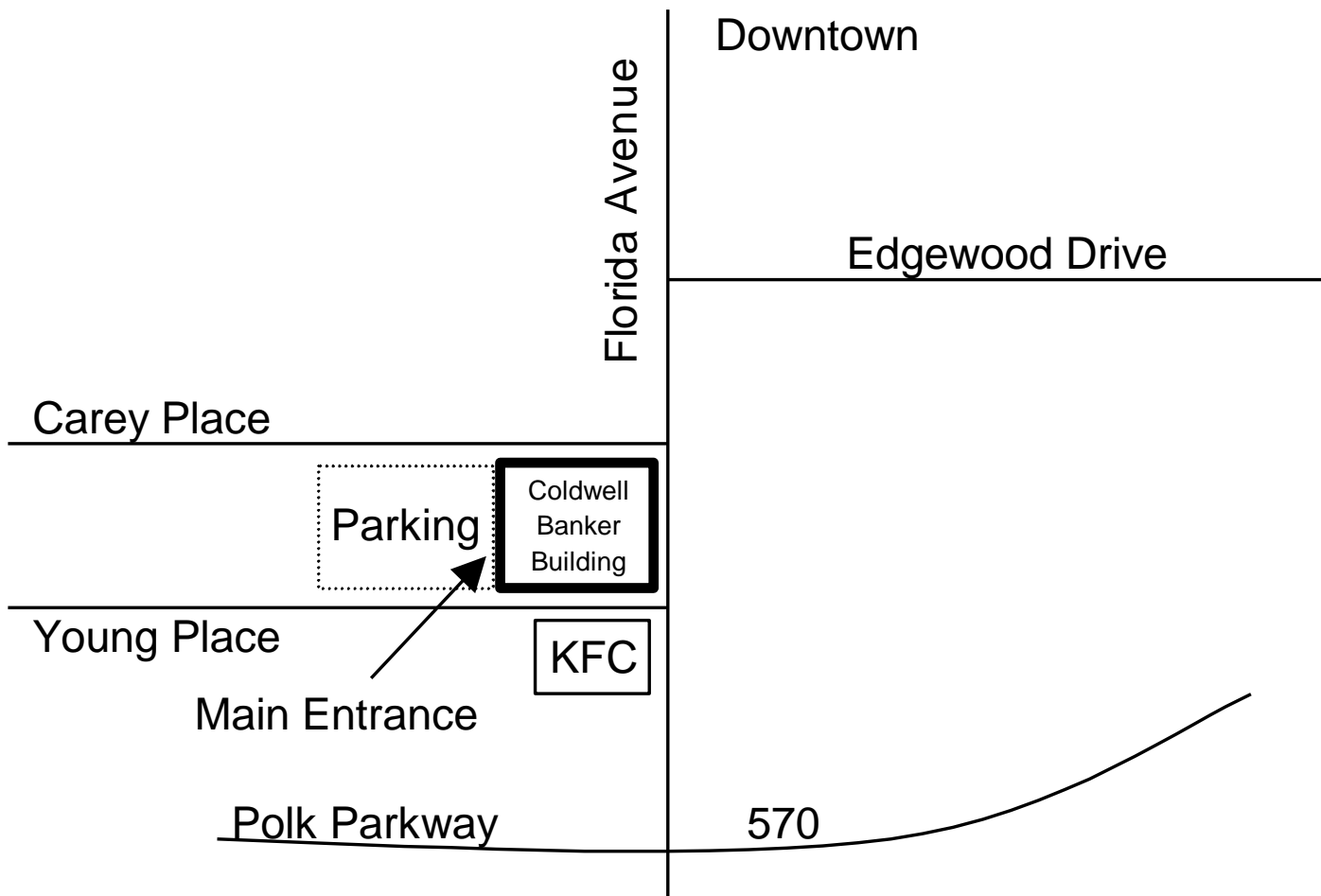
Do you want to be placed on a cancellation list? If so, you may get an earlier appointment.

If you have any additional questions, please call **863-688-2700**. You may be asked to leave a message for the Sleep Coordinator. Please leave your name, number and message. She will return your call as soon as she is available.

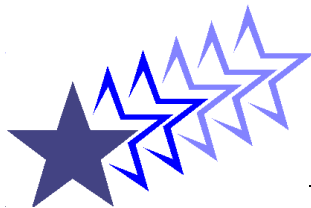


POLK STARLIGHT SLEEP LABS

Sleep Apnea and Sleep Disorder Diagnostic and Treatment Labs
www.StarlightSleep.com



3003 South Florida Avenue, Suite 203
Falcon Professional Center
(Coldwell Banker Building)



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Oxygen Information

1) Do you use any home oxygen during sleep or with activity or both?

Yes

No

Both

2) If yes, what number is your tank set on? _____

3) If you do wear continuous oxygen please make sure you bring enough tanks with you to get you to and from the appointment. Then we will supply you with enough oxygen during your appointment.

SLEEP DISORDER EVALUATION

When registering, please present proof of insurance, Medicare and /or Medicaid.
 Payment is expected at the time of service unless special arrangements are made.

PATIENT INFORMATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Martial Status: _____
 Date of Birth: _____ Age: _____ Sex: M F
 Driver's License Number: _____ State: _____
 Social Security Number: _____
 Student: Y N Referred by: _____
 E-Mail Address: _____

PATIENT'S EMPLOYER

Employer: _____
 Occupation: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____

PATIENT'S SPOUSE/GUARDIAN

Spouse/Guardian: _____
 Relationship: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____ Phone: _____

RESPONSIBLE PARTY (if other than patient)

Name: _____ DOB: _____ SS: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____ Phone: _____
 Social Security Number: _____
 Emergency Contact (not living with you): _____
 City: _____ State: _____ Zip: _____
 Phone: _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of claims to be paid to the Physician or Physicians Group submitting the appropriate claim.

Signature: _____ Date: _____

4. On the scale below, please estimate the severity of your problem(s).

- Mildly upsetting
- Moderately severe
- Very severe
- Extremely severe
- Totally incapacitating

5. How strongly do you want help with your problem?

- Very much
- Much
- Moderately
- Could do without it

6. How do you describe your sleep problem?

- Difficulty falling asleep
- Wake up during the night
- Wake up in the early morning
- Excessive daytime sleepiness
- Difficulty awakening

7. Do any other members of your family have sleep problems? Please explain.

8. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

- | | |
|--|--|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Nutritionist |
| <input type="checkbox"/> Other Internists | <input type="checkbox"/> Counselor |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Other Physician | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> Clergyman |
| <input type="checkbox"/> Other: _____ | |

9. What treatments have you received?

10. Please rate how often you:

N: Never (or NO) R: Rarely O: Occasionally F: Frequently C: Constantly

Awaken from sleep short of breath	N R O F C
Awaken at night with heartburn, belching, or cough	N R O F C
Snore	N R O F C
Snore loudly enough that others complain	N R O F C
Have trouble sleeping when you have a cold	N R O F C
Suddenly wake up gasping for breath during the night	N R O F C
Have breathing problems at night (observed by others)	N R O F C
Sweat excessively at night	N R O F C
Notice your heart pounding or beating irregularly during the night	N R O F C
Fall asleep during the day	N R O F C
Fall asleep involuntarily	N R O F C
Fall asleep while driving	N R O F C
Fall asleep during physical effort	N R O F C
Fall asleep when laughing or crying	N R O F C
Experience loss of muscle tone when extremely emotional	N R O F C
Have trouble at school or work because of sleepiness	N R O F C
Feel unable to move (paralyzed) when waking or falling asleep	N R O F C
Experience vivid dreamlike scenes upon awakening or falling asleep	N R O F C
Feel afraid of going to sleep	N R O F C
Have nightmares	N R O F C
Remember your dreams	N R O F C
Have thoughts racing through your mind	N R O F C
Feel sad or depressed	N R O F C
Have anxiety (worry about things)	N R O F C
Have muscular tension	N R O F C
Notice parts of your body jerk	N R O F C
Kick during the night	N R O F C
Experience crawling and aching feelings in your legs	N R O F C
Experience any type of leg pain during the night	N R O F C
Have morning jaw pain	N R O F C
Grind teeth during sleep	N R O F C
Bothered by pain during the day	N R O F C
Awakened by pain during the night	N R O F C
Wake up feeling stiff in the morning	N R O F C
Wake up with sore or achy muscles	N R O F C
Wake up with pain in the neck, spine, or joints	N R O F C

11. Is your present situation satisfactory?

- Yes
- No

12. Underline any of the following that apply to you.

- | | |
|---|----------------------------|
| Headaches | Dizziness |
| Palpitations | Stomach trouble |
| Bowel disturbances | Fatigue |
| Nightmares | Take sedatives |
| Feel tense | Feel panicky |
| Depressed | Suicidal ideas |
| Unable to relax | Sexual problems |
| Do not like weekends and vacations | Overambitious |
| Cannot make friends | Memory problems |
| Cannot keep a job | Inferiority feelings |
| Financial problems | Fainting spells |
| No appetite | Insomnia |
| Alcoholism | Tremors |
| Take drugs | Shy with people |
| Cannot make decisions | Have conditions bad |
| Unable to have a good time | Concentration difficulties |
| Take antacids regularly (Tums, Tagamet, etc.) | Others: _____ |

13. Underline any of the following words that apply to you.

- | | | | |
|---------------|-----------------|---------------|----------------------------|
| Worthless | Useless | A "nobody" | "Life is empty" |
| Inadequate | Stupid | Incompetent | Naive |
| Guilty | Evil | Morally wrong | "Cannot do anything right" |
| Hostile | Full of hate | Anxious | Horrible thoughts |
| Agitated | Cowardly | Unassertive | Panicky |
| Aggressive | Ugly | Deformed | Unattractive |
| Repulsive | Depressed | Lonely | Unloved |
| Misunderstood | Bored | Restless | Confused |
| Unconfident | Full of regrets | Worthwhile | Sympathetic |
| Intelligent | Attractive | Confident | Considerate |
| Others: | | | |

14. Does your sleep problem disturb your sex life? (Provide any information about any significant relationships.)

15. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?

16. How many hours of sleep do you usually get per night? _____

17. What time do you usually go to be on WEEKDAYS? _____ WEEKENDS? _____

18. How long does it take for you to fall asleep? _____

19. How many times do you typically wake up at night? _____

20. If you wake up, on the average, how long do you stay awake? _____

21. If you do awaken during the night (after you first fall asleep), which part(s) of your sleep period is it?

- Soon after falling asleep
- Middle of the night
- Early morning

22. What do you usually do when you awaken during the night?

23. What time do you usually awaken on WEEKDAYS? _____ WEEKENDS? _____

24. On average, how long do you stay in bed after waking up in the morning? _____

25. Do you usually (check all that apply)?

- Sleep with someone else in your bed
- Sleep with someone else in your room
- Provide assistance to someone during the night (child, invalid, bed partner, animal)

26. Is your sleep often disturbed by?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Light |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Bed partner |
| <input type="checkbox"/> Noise | <input type="checkbox"/> Not being in your normal bed |
| <input type="checkbox"/> Other: _____ | |

27. Are your sleep habits on weekends different from the rest of the week?

- No Yes; please describe: _____

28. With whom are you now living with (wife, husband, children, parents, etc.; please list ages)?

29. Do you work split shift or rotating (variable) shifts?

- Yes No

30. Do you usually drink coffee or tea within hours before going to bed?

- Yes No

31. Do you do physical exercise before bedtime?

- Yes No

32. Do you read before falling asleep?

- Yes No

33. Do you watch TV before falling asleep?

- Yes No

34. Do you take naps in the afternoon or evening?

- Yes No

35. Do you feel refreshed after a short (10-15 minute) nap?

- Yes No

36. How do you feel after an average night of sleep?

- Usually drowsy and/or tired; If so, how long?
 1 hour 2 hours 3 hours or longer Most of the time
 Consistently good

37. Do you feel better during?

- Morning Afternoon Evening

38. Do you take any kind of medication?

<u>Name</u>	<u>Amount</u>	<u>How Often</u>	<u>Reason</u>

39. List your consumption of the following per day.

Coffee	_____	Alcohol	_____
Tea	_____	Colas	_____
Chocolate	_____	Over-the-counter drugs	_____
Nicotine	_____	Other drugs	_____

40. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 estimate how they would have affected you. Use the following scale to choose the most appropriate number in each situation.

0=would never 1=slight chance 2=moderate chance 3=high chance

	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in public place (i.e., a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking with someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

41. What is your personal interpretation as to why you have your particular sleep/wake problem?

42. Please describe any other information pertinent to your sleep or wakefulness not previously described.

Here is a quick test that can help determine the quality of your sleep. If you experience any of the following symptoms on a regular basis, check the box beside each which applies to you.

<input type="checkbox"/> 1. I have been told that I snore loudly. <input type="checkbox"/> 2. I have been told that I stop breathing or gasp for breath while I sleep, although I do not remember this when I wake up. <input type="checkbox"/> 3. I have high blood pressure. <input type="checkbox"/> 4. My friends and family say they have noticed changes in my personality. <input type="checkbox"/> 5. I am gaining weight. <input type="checkbox"/> 6. I sweat excessively during the night. <input type="checkbox"/> 7. I have noticed my heart pounding/beating irregularly during the night. <input type="checkbox"/> 8. I get morning headaches. <input type="checkbox"/> 9. I seem to be losing my sex drive. <input type="checkbox"/> 10. No matter how hard I try to stay awake, I still all asleep, even after a full night's sleep. <input type="checkbox"/> 11. When I experience strong emotions, such as anger, fear, or surprise, I go limp. <input type="checkbox"/> 12. I have fallen asleep while driving, even after a full night's sleep. <input type="checkbox"/> 13. I experience vivid dreamlike scenes upon or soon after falling asleep. <input type="checkbox"/> 14. I have fallen asleep during physical effort. <input type="checkbox"/> 15. I feel as though I have a cram a full day into every hour to get anything done. <input type="checkbox"/> 16. I have trouble at work or at school because of sleepiness. <input type="checkbox"/> 17. I often feel paralyzed (unable to move) for brief periods when falling asleep or just after awakening.	<input type="checkbox"/> 18. I have used antacids (Rolaids, Tums, Alka-Seltzer, etc.) almost every week for stomach troubles and wake up with heartburn. <input type="checkbox"/> 19. I have chronic cough. <input type="checkbox"/> 20. I have morning hoarseness. <input type="checkbox"/> 21. I wake up a night coughing or wheezing. <input type="checkbox"/> 22. I have frequent sore throats. <input type="checkbox"/> 23. Even though I slept through the night, I still feel sleepy during the day. <input type="checkbox"/> 24. Other than when I am exercising, I still experience muscle tension, aching, or crawling sensations in my legs. <input type="checkbox"/> 25. I have been told that I kick at night. <input type="checkbox"/> 26. I experience leg pain during the night. <input type="checkbox"/> 27. Sometimes I just cannot keep my legs still at night. I just have to move them. <input type="checkbox"/> 28. I awaken with sore or aching muscles. <input type="checkbox"/> 29. Thoughts race through my mind and this prevents me from sleeping. <input type="checkbox"/> 30. I wake up during the night and cannot go back to sleep. <input type="checkbox"/> 31. I worry about things and have trouble relaxing. <input type="checkbox"/> 32. I wake up earlier in the morning than I would like to. <input type="checkbox"/> 33. I lie awake for a half hour or more before I fall asleep. <input type="checkbox"/> 34. I feel sad and depressed. I feel afraid to go to sleep.
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Score yourself:

Questions 1 through 10 – Describe symptoms experienced by people with *SLEEP APNEA*, a potentially life threatening disorder which causes you to stop breathing repeatedly, often several hundred times per night, during your sleep.

Questions 11 through 17 - Describe symptoms experienced by people with *Narcolepsy*, a lifelong disorder characterized by uncontrollable sleep attacks during the day.

Questions 18 through 23 – Describe symptoms experienced by people with *GASTROESOPHAGEAL REFLUX*, a disorder caused when stomach acid backs up into the throat during the night.

Questions 24 through 28 – Describe symptoms experienced by people with *NOCTURNAL MYOCLONUS* or *RESTLESS LEGS SYNDROME*, a disorder characterized by pain or crawling sensations in the legs.

Questions 29 through 34 – Describe symptoms experienced by people with *INSOMNIA*, a persistent inability to fall asleep or stay asleep.

REMEMBER, the test you have just completed describes symptoms that are similar to those individuals with sleep disorders. It is intended as a general source of educational information and should not be used for diagnosis or treatment. Your physician can refer you to a comprehensive sleep center where you can be assured that you will get an in-depth evaluation by highly qualified medical personnel.

3003 South Florida Avenue Suite 203 Lakeland Florida 33803 863-688-2700 863-688-8240 Fax
 "A Central Florida Physicians Alliance Lab"
www.StarlightSleep.com

Medical History

Year of last full physical examination: _____

Significant changes in weight in last year (i.e., after quitting smoking, surgery, through diet):

Gained _____ Lost _____

List diagnoses (and dates) that have been given to you:

Mental health (i.e., depression, suicide, alcoholism):

Nervous system (i.e., strokes, seizures, diabetic nerve damage):

Ears, eyes, nose, and throat (i.e., nasal allergies, polyps, tumors):

Heart/circulation (i.e., heart attacks, failure, irregular heartbeats, mitral valve prolapse):

Blood pressure (i.e., high or low blood pressure):

Breathing (i.e., asthma, bronchitis, emphysema):

Stomach (i.e., swallowing difficulties, heartburn, indigestion, hiatal hernia, ulcers):

Bowels (i.e., diarrhea, constipation, cancer):

Urinary or kidney (i.e., infection with frequent nighttime urination or diuretics, stones, cancer):

Sexual (i.e., loss of desire, impotence, penile implant/testosterone shots):

Hormones (i.e., high or low thyroid conditions, prescribed steroids, prednisone/estrogen, for menopause):

Blood (i.e., "low blood" or anemia, thick blood, sickle cell disease, HIV infection):

Chronic pain (i.e., arthritis, broken hip, osteoporosis):

Surgeries (i.e., tonsillectomy, adenoidectomy, nose, jaw, or face surgery, hysterectomy-partial/full):

Please check appropriate space if you have had any of these illnesses:

CHILDHOOD: Rheumatic Fever _____ Mumps _____ Asthma _____
Scarlet Fever _____ Measles _____ Other _____

ADULT: Glaucoma _____ Stroke or Paralysis _____
High Blood Pressure _____ Diabetes _____
Stomach Ulcers _____ Arthritis _____
Hepatitis/Jaundice _____ Gout _____
Cirrhosis of Liver _____ Thyroid Disease _____
Colitis _____ Anemia _____
Diverticulitis _____ Tuberculosis _____
Gallstones _____ Hay Fever _____
Pancreatitis _____ Pneumonia _____
Kidney Stones _____ Pleurisy _____
Gonorrhea/Syphilis _____ Bronchitis _____
Depression _____ Emphysema _____
Nervous Breakdown _____ Heart Disease _____
Epilepsy/Seizures _____ Cancer _____

HOSPITALIZATIONS AND SURGERIES (please list all your hospitalizations and surgeries):

19 _____ Reason _____ Doctor/Hospital _____
19 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____

FAMILY HISTORY: Father Living _____ Age _____ Deceased _____ Age _____
Illnesses _____ Cause of Death _____
Mother Living _____ Age _____ Deceased _____ Age _____
Illnesses _____ Cause of Death _____

List the name, living, age, and illnesses:

BROTHERS: _____ SISTERS: _____

Please check if any of your blood relatives have had any of the following:

Asthma _____ High Blood Pressure _____ Epilepsy _____
Emphysema _____ Heart Disease _____ Cancer _____
Bronchitis _____ Stroke _____ Hay Fever _____
Tuberculosis _____ Arthritis _____ Anemia _____
Diabetes _____ Gout _____ Other: _____

REVIEW OF SYSTEMS (If you have had any of these symptoms within the last 6 months, please put a check by them. If you are unsure, please put a ?):

Weight _____ Have you gained or lost over 10 pounds in the past year? _____

SKIN

- _____ Chronic skin irritation
- _____ Lump or growth
- _____ Change in skin color
- _____ Skin cancers

EYES

- _____ Glasses
- _____ Change in vision
- _____ Pain in eyes
- _____ See halo around lights

EARS

- _____ Trouble hearing
- _____ Earaches
- _____ Discharge from ears
- _____ Buzzing or ringing in ears

NOSE AND THROAT

- _____ Frequent sneezing
- _____ Nose continually stuffy or runny
- _____ Frequent sore throats
- _____ Hoarseness

BREAST

- _____ Lump
- _____ Discharge
- _____ Pain

HEART AND LUNG

- _____ Chest pain with activity
- _____ Other chest pain
- _____ Shortness of breath
- _____ Sleep with more than one pillow to help you breathe
- _____ Blood in sputum
- _____ Wheezing
- _____ Unusual heartbeat
- _____ Heart attack
- _____ Swollen ankles

GENERAL

- _____ Loud snoring
- _____ Unusual fatigue
- _____ Unusual weakness
- _____ Swollen lymph glands
- _____ Fever in past month
- _____ Night sweats

ENDOCRINE

- _____ Frequent urination
- _____ Unusual thirst

GENITOURINARY

- _____ Painful urination
- _____ Frequent urination
- _____ Blood in urine
- _____ Discharge from vagina or penis
- _____ Blood or pus in urine
- _____ Difficulty starting urinating

MUSCULOSKELETAL

- _____ Painful joints
- _____ Sore muscles
- _____ Back pain
- _____ Unusual weakness

NEUROPSYCHIATRIC

- _____ Frequent or severe headaches
- _____ Dizziness or fainting
- _____ Depressed
- _____ Convulsions/epilepsy

LUNGS

Shortness of breath:

- _____ at rest
- _____ walking uphill or upstairs
- _____ walking level with others your own age
- _____ walking level at your own pace
- _____ washing or dressing

How far can you walk without stopping? _____

Do you exercise regularly? _____

What type? _____

STOMACH AND LIVER

- _____ Frequent heartburn/indigestion
- _____ Frequent nausea or vomiting
- _____ Stomach pain
- _____ Constipation
- _____ Bleeding ulcers
- _____ Hemorrhoids
- _____ Blood in bowel movements
- _____ Loss of appetite
- _____ Vomiting blood
- _____ Black bowel movements

PRIVACY PRACTICES ACKNOWLEDGEMENT

**Polk Starlight Sleep Labs
3003 S. Florida Ave.
Suite 203
Lakeland, Florida 33803
Phone: (863) 688-2700**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy at our offices.

You have the right to request we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures already made in reliance on your prior Consent. The Practice provides this form to comply with the health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this Consent.

I, _____, acknowledge receipt of the Notice of Privacy Practices from Polk Starlight Sleep Labs.

Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Date: _____ / _____ / _____

PATIENT QUESTIONNAIRE

**Polk Starlight Sleep Labs
3003 S. Florida Avenue
Suite 203
Lakeland, Florida 33803
Phone: (863) 688-2700**

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

IV. Please indicate if you want all correspondence from our office to be sent sealed in an envelope marked "CONFIDENTIAL".

_____ YES _____ NO

V. Please print the telephone number where you want to receive all calls about your appointments, lab and x-ray results, or other health care information, if other than your home phone number.

VI. Can confidential messages (ie: appointment reminders) be left on your telephone answering machine or voicemail?

_____ YES _____ NO

Patient Name: _____

Patient/Guardian Signature: _____ Date: __/__/__