

## Appointment Reminder

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Appointment Address: **777 N 5<sup>th</sup> Avenue, Suite 106, Sequim**

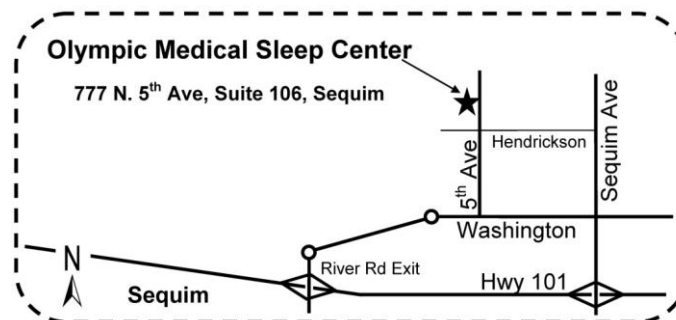
Appointment Date: \_\_\_\_\_ Check In Time: \_\_\_\_\_

Provider:  Michael McDonald, MD  
 Usha Reddi, MD  
 Marna Butler, ARNP

### Please do the following:

- **Fill out all of the enclosed forms.**
- **Bring the completed forms** to your appointment.
- **Bring your insurance cards, photo ID** and any **Advanced Healthcare Directive** you may have (IE. POLST form, Durable Power of Attorney for Healthcare, etc) to your appointment.
- Please contact us at (360) 582-4200 if you need to reschedule or cancel your appointment.
- Please remember to bring your **medication(s)** including herbs and supplements in their original bottles or an **updated** medications list.

### Directions:



#### If you are coming from Port Angeles:

1. Follow US-101 E
2. Take the River Rd exit
3. Turn LEFT onto River Rd.
4. Turn RIGHT onto Washington St.
5. At the traffic circle, continue STRAIGHT to stay on Washington St
6. At SECOND light turn LEFT onto 5<sup>th</sup> Ave
7. At light continue STRAIGHT on 5<sup>th</sup> Ave  
Sequim Medical Plaza will be on the LEFT

#### If you are coming from East of Sequim:

1. Head NORTHWEST on US-101 W
2. Take the Sequim Ave exit
3. Turn RIGHT onto Sequim Ave
4. Turn LEFT onto Washington St.
5. Turn RIGHT onto 5<sup>th</sup> Ave
6. At light continue STRAIGHT on 5<sup>th</sup> Ave  
Sequim Medical Plaza will be on the LEFT

**Thank you for choosing Olympic Medical Sleep Center!**

# Registration and Update Form (Confidential)



- Please complete all > **Required sections** of this form then
- Provide an **Insurance Card** and **Photo ID** for copying
- If you have any questions or concerns, please ask for assistance. We will be happy to help.

## > Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Mark the best)  Home: \_\_\_\_\_  Work: \_\_\_\_\_

Mobile: \_\_\_\_\_  Message: \_\_\_\_\_

Aliases / Nick Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

## > General Needs Interpreter If yes; Language: \_\_\_\_\_ Religion: \_\_\_\_\_

**Marital Status:**  Married  Single  Divorced  Widowed  Legally Separated

**Ethnicity:**  Hispanic  American Indian/Alaskan Native  Asian  Black/African American

Native Hawaiian/Pacific Islander  White/Caucasian  Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Employment Status:  Part Time  Full Time

Never Employed  Not Employed  Active Military Duty  Disabled  Retired  Self Employed

Student Full Time  Student Part Time

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Primary Care Doctor (Doctor, Nurse Practitioner, Physicians Assistant, etc.)

Dr. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Patient Emergency Contacts-At least 1 immediate family member

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Financially Responsible Party (Guarantor) (Complete if Guarantor is the parent or anyone other than the patient)

Guarantor Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employment Status:  Part Time  Full Time

Never Employed  Not Employed  Active Military Duty  Disabled  Retired  Self Employed

Student Full Time  Student Part Time

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Coverage Information

**Primary Insurance:** \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## > Advanced Directives Do you have any Advanced Directives? Yes No



# Patient History

PLEASE PRINT This information becomes part of your confidential medical record

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Presenting Problem: Please describe the specific problems or questions you would like to have addressed

\_\_\_\_\_

### Medications (include supplements and over the counter drugs)

Name	Dose	Frequency	Purpose

Pharmacy/ Local: \_\_\_\_\_

Mail Order: \_\_\_\_\_

### Allergies

Agent	Reaction

### Past Surgical History

Type of surgery	Date	Surgeon/City	Reason

### Family History

Relationship	Age	Medical Conditions / Cause of death
Mother	<input type="checkbox"/> deceased	
Father	<input type="checkbox"/> deceased	
Brother(s) # _____	<input type="checkbox"/> deceased	
Sisters(s) # _____	<input type="checkbox"/> deceased	
Children # _____	<input type="checkbox"/> deceased	

### Social History / Habits

Married  
  Single  
  Divorced  
 Children:  
  No  
  Yes if yes: Number of Children: \_\_\_\_\_

Sexually Active:  
 Yes  
 No

Occupation: \_\_\_\_\_

**Smoking/Tobacco:**  
 Never  
 Yes, year started: \_\_\_\_\_  
 Quit; year quit: \_\_\_\_\_

cigarettes:  
 Yes  
 No  
 pks/day: \_\_\_\_\_

cigars:  
 Yes  
 No  
 cigars/day: \_\_\_\_\_

smokeless:  
 Yes  
 No  
 cans/day: \_\_\_\_\_

**Alcohol:**  
 Yes  
 No  
 drinks/day: \_\_\_\_\_

**Marijuana:**  
 Yes  
 No  
 amt: \_\_\_\_\_

**Street drugs:**  
 Yes  
 No  
 type: \_\_\_\_\_

**Caffeine:**  
 Yes  
 No  
 type: \_\_\_\_\_  
 cups/day: \_\_\_\_\_

**Exercise:**  
 Yes  
 No  
 type: \_\_\_\_\_  
 amount: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Medical History (Please mark any conditions you've been diagnosed with in the past)**

- Glaucoma
- Cataracts
- Macular degeneration
- Hearing loss
- High blood pressure
- High cholesterol
- Angina
- HIV/AIDS
- Diverticulitis
- Hepatitis
- Reflux / GERD / Ulcers
- Hiatal hernia
- Kidney stones
- Diabetes
- Thyroid disease
- Stroke
- Seizure / Epilepsy
- Anemia
- Blood clots
- Arthritis
- Psoriasis
- Eczema
- Depression
- Fibromyalgia
- Gout
- Atrial Fibrillation/Arrhythmia
- Heart Attack
- Coronary Artery Disease
- Congestive heart failure
- Pacemaker
- Asthma
- COPD / Emphysema
- Tuberculosis
- Pulmonary embolus

Cancer: Type: \_\_\_\_\_

Other: \_\_\_\_\_

For children less than 5 years old: Birth Weight \_\_\_\_\_  Complications  Breech

**Review of Systems (Please complete the following by checking Yes or No)**

General	YES	NO
Fever		
Chills		
Weight loss		
Malaise/Fatigue		
Sweating		
Weakness		

Cardiovascular	YES	NO
Chest pain		
Palpitations		
Shortness of breath laying down		
Pain in limbs		
Leg swelling		
Shortness of breath at night		

Musculoskeletal	YES	NO
Muscle pain		
Neck pain		
Back pain		
Joint pain		
Falls		

Skin	YES	NO
Rash		
Itching		

Respiratory	YES	NO
Cough		
Coughing up blood		
Sputum production		
Shortness of breath		
Wheezing		

Endo/Heme/Aller	YES	NO
Easy bruise/bleed		
Environmental allergies		
Excessive thirst		

HENT	YES	NO
Headaches		
Hearing loss		
Ringing in ears		
Ear pain		
Ear discharge		
Nosebleeds		
Congestion		
Upper airway wheezing		
Sore throat		

Gastrointestinal	YES	NO
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Black stools		

Neurological	YES	NO
Dizziness		
Tingling		
Tremor		
Loss of feeling		
Speech change		
Focal weakness		
Seizures		
Loss of consciousness		

Eyes	YES	NO
Blurred vision		
Double vision		
Light sensitivity		
Eye pain		
Eye discharge		
Eye redness		

Genitourinary	YES	NO
Painful urination		
Urgency		
Frequency		
Blood in urine		
Flank pain		

Psychiatric	YES	NO
Depression		
Suicidal ideas		
Substance abuse		
Hallucinations		
Nervous/Anxious		
Insomnia		
Memory loss		

Other: \_\_\_\_\_

Contraception:  Yes  No Type: \_\_\_\_\_

Vaginal Deliveries: # \_\_\_\_\_ C-Section: # \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

Miscarriages / Abortions # \_\_\_\_\_

# Sleep History and Questionnaire



## Patient Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

## Sleep Problems Please check all that apply

- |                                                          |                                                                  |
|----------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Difficulty falling asleep       | <input type="checkbox"/> Walk or talk in your sleep              |
| <input type="checkbox"/> Difficulty maintaining sleep    | <input type="checkbox"/> Legs that ache or move a lot at night   |
| <input type="checkbox"/> Snoring                         | <input type="checkbox"/> Unknowingly strike at my bed-partner    |
| <input type="checkbox"/> Stop breathing at night (apnea) | <input type="checkbox"/> Heartburn that keeps me awake           |
| <input type="checkbox"/> Bad dreams or nightmares        | <input type="checkbox"/> Feel sleepy during the day              |
| <input type="checkbox"/> Nasal obstruction at night      | <input type="checkbox"/> Fall asleep unexpectedly during the day |

Please describe any other sleep symptoms or problems:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever consulted a medical professional for this problem?  Yes  No

What treatment did you receive for this problem?

\_\_\_\_\_

## Sleep Environment Please estimate the number of times per week any of these items occur.

- x \_\_\_\_\_ I can see light in my bedroom during my sleep time, e.g. from windows, electronic devices or lights.
- x \_\_\_\_\_ Pets in the bedroom.
- x \_\_\_\_\_ Excessive heat or cold causing me to awaken.
- x \_\_\_\_\_ Noise that awakens me, e.g. road noise, noisy neighbors, bedroom or other noises in the home.
- x \_\_\_\_\_ Bed partner's snoring, movement or schedule awakens me.
- x \_\_\_\_\_ Uncomfortable bed that causes me to awaken.
- x \_\_\_\_\_ Pain that prevents me from falling asleep or awakens me at night.
- x \_\_\_\_\_ Frequent bathroom visits during the night. Number of times per *night*. x \_\_\_\_\_

## Sleep Hygiene Please check all that apply

- |                                                                            |                                                              |
|----------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> I watch TV in the bedroom                         | <input type="checkbox"/> I watch TV until bedtime            |
| <input type="checkbox"/> I work on my computer in the bedroom              | <input type="checkbox"/> I work on my computer until bedtime |
| <input type="checkbox"/> I do house work until bedtime                     | <input type="checkbox"/> I do work for my job until bedtime  |
| <input type="checkbox"/> I exercise within 3 hours of bedtime              | <input type="checkbox"/> My mind races when I go to bed      |
| <input type="checkbox"/> I am on call at night (either for family or work) | <input type="checkbox"/> I read novels until bedtime         |

## Sleep Schedule Please fill out the sleep diary on page 3

How many hours sleep do you usually get per night? \_\_\_\_\_

Work shift:  Day  Swing  Graveyard  Rotating  Split  Other

What are your work hours? \_\_\_\_\_

What is your usual bedtime? \_\_\_\_\_

Do you nap during the day?  Yes  No

How long do you nap? \_\_\_\_\_

What time is your usual nap time? \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Dietary Factors affecting your sleep**

I drink \_\_\_\_\_ ounces of caffeinated coffee before 10:00 AM. After 10:00 AM \_\_\_\_\_  
I drink \_\_\_\_\_ ounces of caffeinated cola before 10:00 AM. After 10:00 AM \_\_\_\_\_  
I drink \_\_\_\_\_ ounces of caffeinated tea before 10:00 AM. After 10:00 AM \_\_\_\_\_  
I smoke \_\_\_\_\_ packs of cigarettes daily.  
I drink \_\_\_\_\_ ounces of beer or \_\_\_\_\_ ounces of wine or \_\_\_\_\_ ounces of alcohol daily.  
I use street drugs or medications for any purpose  No  Yes, please list: \_\_\_\_\_  
I have used the following medications to improve my sleep. \_\_\_\_\_

**My Sleep Score** Please check all words that express how you feel about yourself.

How likely are you to “doze off” or fall asleep in the situations described below?

Use the following scale to select the number that is most appropriate for you.

Write your number in the space next to each situation on next page.

Total and record your score in the appropriate space

0 = Never    1 = Rarely    2 = Occasionally    3 = Regularly

- \_\_\_\_\_ Sitting and reading
- \_\_\_\_\_ Watching television
- \_\_\_\_\_ Sitting inactive in a public place like a meeting or classroom
- \_\_\_\_\_ As a passenger in a car for one hour
- \_\_\_\_\_ Lying down to rest in the afternoon
- \_\_\_\_\_ Sitting quietly after lunch (without alcohol)
- \_\_\_\_\_ In a car while stopped for a few minutes in traffic

**Total Score**

Score results:

- 1-6 Good, you appear to be getting sufficient sleep.
- 7-8 Average, but more or better sleep may be needed.
- 9-24 Excessively sleepy, an evaluation by a sleep specialist is recommended.

# Sleep Diary

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



Instructions: When filling out this sleep diary, estimate, to the best of your ability, the answers to the questions about your sleep for the night before. For example: if you begin this diary on Monday, on Tuesday morning estimate the answers for Monday and Monday night and record them in the column labeled "Day 1". Use the example column to help you format your answers.

	Example	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Prior to going to bed I napped from _____ to _____. (Note times of all naps)	1:30 to 2:30 pm							
I took _____ mg of medication and/or _____ oz. of alcohol before bed to help me sleep.	<i>Ambien</i> 10 mg							
I went to bed and turned the light off at _____ o'clock.	11:15 pm							
After turning the lights off, I fell asleep in _____ minutes	35 min.							
My sleep was interrupted _____ times during the night. Specify the number of awakenings.	3							
My sleep was interrupted for _____ minutes with each of the interruptions noted above	10, 5, 20							
This morning I awakened at _____ o'clock (Time of last awakening)	6:15 am							
This morning I got out of bed at _____ o'clock	6:40 am							
When I got up this morning I felt _____ 1 = exhausted to 5 = very refreshed	2							
Overall, my sleep last night was _____ 1 = very restless to 5 = very sound and restful	3							



PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION



PATIENT INFORMATION

Patient Name (printed): Previous Name(s):
Date of Birth: Daytime Telephone Number:

INFORMATION TO BE RELEASED FROM:

I hereby authorize Olympic Medical Physicians Clinics to release the following information contained in my medical record and/or information regarding my medical care or condition as described in detail below.

INFORMATION TO BE RELEASED TO:

Name: Relationship: Phone Number:
Name: Relationship: Phone Number:
Name: Relationship: Phone Number:

GENERAL INFORMATION TO BE RELEASED

- You may release test results and appointment information to the above named person(s)
You may discuss my medical condition(s) and/or current treatment with the above named person(s)

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

- Drug and Alcohol Abuse/Treatment
Mental Health/Psychiatric Disorders
HIV/AIDS Virus
Sexually Transmitted Diseases

CONSENT TO DISCLOSE

By my signature below I indicate that I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization will be valid until:

Date Signature of patient or representative Relationship to patient

FOR FACILITY USE ONLY

Date Received: Date Information Released: Chart #:
Person/Department Sending Records:
Faxed Mailed Picked Up: Other:



# Financial Assistance Plain Language Summary

## Do I qualify?

Based on your income and family size, you may qualify for a discount of 30-100% of your bill.

In some cases, we'll evaluate criteria other than income. For example, if you experience a catastrophic event, you may qualify regardless of income.

## Examples:

Individual with  
\$18,000 income  
= 60% discount



Couple with  
\$48,000 income  
= 30% discount



Family of four with  
\$24,000 income  
= 100% discount



For a full list of family incomes, family sizes, and discounts, see the next page.

## What does the Program cover?

The Program covers medically necessary care provided by us or by one of our providers.

## How do I apply?

Consult a Patient Financial Service Representative at 360-417-7111 for help applying. For a free copy of the entire Financial Assistance Policy and an application:

- **Online:** [www.olympicmedical.org](http://www.olympicmedical.org) then go to Patients & Visitors, Billing & Financial Services
- **In Person:** Visit the Patient Financial Services Department at 519 S Peabody, Port Angeles, WA 98362  
Office hours are Monday-Friday 8:00 AM to 4:30 PM
- **Mail:** Mail a request to Olympic Medical Center, 519 S Peabody, Port Angeles, WA 98362
- **Telephone:** Call Patient Financial Services at (360) 417-7111 or (800) 854-2844

Mail or bring your completed application and required documentation to Olympic Medical Center, 519 S Peabody St., Port Angeles, WA 98362. We process submitted applications only once they are complete. If your application is not complete, we will notify you and provide an opportunity to send the missing documentation or information.

Olympic Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish  
Español

Olympic Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-360-417-7000 TTY: 1-360-417-8686

Chinese  
繁體中文

Olympic Medical Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-360-417-7000 TTY: 1-360-417-8686



## Financial Assistance Sliding Scale 2018

Gross Monthly Income					
Family Size	100% Discount (100% FPG)	80% Discount (125% FPG)	60% Discount (150% FPG)	45% Discount (200% FPG)	30% Discount (300% FPG)
1	0 - 1012	1,013 - 1,265	1,266 - 1,518	1,519 - 2,023	2,024 - 3,035
2	0 - 1372	1,373 - 1,715	1,716 - 2,058	2,059 - 2,743	2,744 - 4,115
3	0 - 1732	1,733 - 2,165	2,166 - 2,598	2,599 - 3,463	3,464 - 5,195
4	0 - 2092	2,093 - 2,615	2,616 - 3,138	3,139 - 4,183	4,184 - 6,275
5	0 - 2452	2,453 - 3,065	3,066 - 3,678	3,679 - 4,903	4,904 - 7,355
6	0 - 2812	2,813 - 3,515	3,516 - 4,218	4,219 - 5,623	5,624 - 8,435
7	0 - 3172	3,173 - 3,965	3,966 - 4,758	4,759 - 6,343	6,344 - 9,515
8	0 - 3532	3,533 - 4,415	4,416 - 5,298	5,299 - 7,063	7,064 - 10,595

Based on Annual Gross Income					
Family Size	100% Discount (100% FPG)	80% Discount (125% FPG)	60% Discount (150% FPG)	45% Discount (200% FPG)	30% Discount (300% FPG)
1	0 - 12,140	12,141 - 15,175	15,176 - 18,210	18,211 - 24,280	24,281 - 36,420
2	0 - 16,460	16,461 - 20,575	20,576 - 24,690	24,691 - 32,920	32,921 - 49,380
3	0 - 20,780	20,781 - 25,975	25,976 - 31,170	31,171 - 41,560	41,561 - 62,340
4	0 - 25,100	25,101 - 31,375	31,376 - 37,650	37,651 - 50,200	50,201 - 75,300
5	0 - 29,420	29,421 - 36,775	36,776 - 44,130	44,131 - 58,840	58,841 - 88,260
6	0 - 33,740	33,741 - 42,175	42,176 - 50,610	50,611 - 67,480	67,481 - 101,220
7	0 - 38,060	38,061 - 47,575	47,576 - 57,090	57,091 - 76,120	76,121 - 114,180
8	0 - 42,380	42,381 - 52,975	52,976 - 63,570	63,571 - 84,760	84,761 - 127,140

Due to yearly updates to this information, there may be a more recent version.  
 The latest version will be posted on our website:  
[www.olympicmedical.org](http://www.olympicmedical.org) then go to Patients & Visitors, Billing & Financial Services