OLYMPIC MEDICAL SLEEP CENTER

SWEDISH Health Network Affiliate

907 Georgiana St., Port Angeles, WA 98362 • (360) 582-4200 • Fax (360) 565-9251
777 N. 5th Avenue, Suite 106, Sequim, WA, 98382 • (360) 582-4200 • Fax (360) 582-4202

Appointment Reminder

Patient Name: _____ Date of Birth: _____

Appointment Address: **777 N 5th Avenue, Suite 106, Sequim**

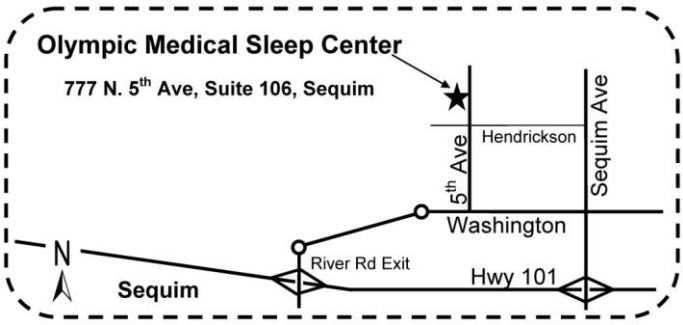
Appointment Date: _____ Check In Time: _____

Provider: ❑ 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 5th Ave
7. At light continue STRAIGHT on 5th 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 5th Ave
6. At light continue STRAIGHT on 5th 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.

OLYMPIC MEDICAL CENTER

➢ 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

OLYMPIC MEDICAL PHYSICIANS

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	❑ deceased	
Father	❑ deceased	
Brother(s) #____	❑ deceased	
Sisters(s) #____	❑ deceased	
Children #____	❑ 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		

Skin	YES	NO
Rash		
Itching		

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

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

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

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

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

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

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

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

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

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

OLYMPIC MEDICAL PHYSICIANS

Patient Information

Todays Date:_____

Name:_____ Date of Birth:_____

Occupation:_____

Sleep Problems **Please check all that apply**

- ❑ Difficulty falling asleep
- ❑ Difficulty maintaining sleep
- ❑ Snoring
- ❑ Stop breathing at night (apnea)
- ❑ Bad dreams or nightmares
- ❑ Nasal obstruction at night
- ❑ Walk or talk in your sleep
- ❑ Legs that ache or move a lot at night
- ❑ Unknowingly strike at my bed-partner
- ❑ Heartburn that keeps me awake
- ❑ Feel sleepy during the day
- ❑ 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 <u>week</u> 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**

- ❑ I watch TV in the bedroom
- ❑ I work on my computer in the bedroom
- ❑ I do house work until bedtime
- ❑ I exercise within 3 hours of bedtime
- ❑ I am on call at night (either for family or work)
- ❑ I watch TV until bedtime
- ❑ I work on my computer until bedtime
- ❑ I do work for my job until bedtime
- ❑ My mind races when I go to bed
- ❑ 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.

OLYMPIC MEDICAL PHYSICIANS

	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.	Ambien 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							

OLYMPIC
MEDICAL PHYSICIANS

PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION

999

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:_____

OLYMPIC MEDICAL CENTER

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 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

OLYMPIC MEDICAL CENTER

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 then go to Patients & Visitors, Billing & Financial Services