GULF COAST SURGICAL ASSOCIATES Anil K. Sinha, MD, FACS 201 Oak Drive South, Suite 203, Lake Jackson, TX 77566

PATIENT INFORMATION

ADDRESS CITY STATE ZIP PHONE (Home) (Work) (Cell) MARITAL STATUS: S M D W BIRTHDATE AGE: SOCIAL SECURITY NUMBER: EMPLOYER: ADDRESS: SPOUSE BIRTHDATE: SSN. BIRTHDATE: SSN. EMERGENCY CONTACT (FRIEND OR RELATIVE) NAME AND PHONE NUMBER: EMPLOYER: SSN. EMERGENCY CONTACT (FRIEND OR RELATIVE) NAME AND PHONE NUMBER: PHARMACY NAME AND CITY: IHEREBY AUTHORIZE THE RELEASEOF MEDICAL INFORMATION FOR THE PROCESSING OF INSURANCE. I hereby assign all medical a surgical benefits to include major medical benefits to which I am entitled to Gulf Coast Surgical Associates. This agreement will remain in effect until revoked in writing by me. Initial IHEREBY AUTHORIZE AND PERMIT Gulf Coast Surgical Associates to examine me and permit them to perform any necessary physical or laboratory texts as in deemed necessary to treat my illness. Patient/Guardian Signature. INSURED PATIENTS: In order for us to bill promptly and correctly, vea must provide as with a copy of your CURRENT insurance card(s). You must notify us of any changes in your coverage as they occur in the future. Failure to provide correct and current information will make you responsible for any other patients. In order for us to bill promptly and correctly, vea must provide as with a copy of your CURRENT insurance card(s). You must notify us of any changes in your coverage as they occur in the future. Failure to provide correct and current information will make you responsible for any of any changes in your coverage as they occur in the future. Failure to provide correct and current information will make you responsible for any of any changes in your coverage as they occur in the future. Failure to provide correct and current information will make you responsible for any of any changes in your coverage as they occur in the future. Failure to provide correct and current information will make you responsible for any of any change in your coverage as they occur in the future. Failure to provide to you by Gulf Coast Surgical Associates. Payment arrangements are	NAME	Pierr						DATE
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Patient/Guardian Printed Name: Signature:	You may refuse right to refuse to treat you some future time you may signed consent. If you have any	to consent to should you c request to re	the use or hoose to re fuse all or	disclosur fuse to dis part of you	e of your p sclose you ir PHI. Yo	personal health inform r Personal Health Info ou may revoke actions	ation, but this must be rmation (PHI). If you that have already be	be in writing. Under this law, we have the ou choose to give consent in this document, at een taken which relied on this or a previously
Printed Name: Signature:	100000000000000000000000000000000000000	o request re	strictions a	nd revoke	consent if	i writing after you hav	e reviewed our priva	acy notice.
	Defeated No.							Date:

ANIL K. SINHA, MD, PA

NAME:		D	ATE OF BIRTH:	
2. *			CAL HISTORY	
BLOOD PRESSURE - LUNG DISEASE- DIABETES- OTHER	NO NO	LOW YES: YES	NORMAL	
		PAST SURGI	CAL HISTORY	
PLEASE LIST ALL SUR	GERIES WHI	CH REQUIRE	D ANESTHESIA:	
IST ALL MEDICATION	S (INCLUDE	OVER THE	COUNTER) YOU CURRENTLY TAKE:	9
ALLERGIES TO MEDICA	٠,			
				1-10-1
OO YOU DRINK	IF YES, F	HOW MUCH_		
MAIN COMPLAINT (WH	Y ARE WE	SEEING YOU	TODAY?)	
AMILY HISTORY (LIST	ALL SERIO	US ILLNESSE	S-PARENTS/GRANDPARENTS/SIBLING	S):
				11-2-2
	10			
RIMARY CARE PHYSIC	IAN:			
VERE YOU REFERRED T			S NO	
		=	THE E CO	

PHYS REV:_

GULF COST SURGICAL CLINIC 201 OAK DRIVE SOUTH, SUITE 203, LAKE JACKSON, TX 77566

INSURANCE INFORMATION

GUARANTOR INFORMATION LAST NAME		FIRST NAME	
RELATIONSHIP TO PATIENT			
ADDRESS			
DATE OF BIRTH	SS#_		HOME PHONE
PRIMARY INSURANCE			
NAME		ADDRESS	
TELEPHONE	ID#_		GROUP #
POLICY HOLDER NAME		ADDRESS	SKOOT #
MPLOYER NAME AND ADDRESS		_	
BIRTHDATE	SS#_		_
ECONDARY INSURANCE			
AME		ADDRESS	
ELEPHONE	ID#	ADDRESS	CDOVEN #
DLICY HOLDER NAME		ADDRESS	GROUP #
MPLOYER NAME AND ADDRESS	2160	ADDRESS_	
IRTHDATE			
ACCORDANCE WITH THE PRIVACY RITTEN INFORMATION REGARDING	ACT PLEASI YOUR RECO	E LIST ANYONE THAT YOU ORDS.	
AME			
AME		RELATIONSHIP	
AME			

Gulf Coast Sleep Center 107 West Way, Ste. 19 & 20 Lake Jackson, TX 77566 Contact Person: Dale Heathcock

281 635 7458

3434 Saratoga Blvd, Suite 101 Corpus Christi, TX 78415 Phone: 361.288.1855

Fax: 361.225.0357

Email: sleep@sleepritecenter.com

Name:_			Date:		
Height:	DOB:Ag	e:	Weight	:M/F:	
Please	circle the number which b	est applies.		· ·	
	Do you snore?		7.	During your wake time, do y	ou feel tired,
1.	Yes	4		fatigued or not up to par?	
	No	0		Nearly every day	3
	Don't know	1		3-4 times a week	2
	Don't know	1		1-2 times a week	3 2 2 1
If you	enore:			1-2 times a month	1
n you .	snore.			Never or nearly never	0
2.	Your snoring is?		8.	Have you ever nodded off or	fallen
	I don't snore	0		asleep while driving a vehicle	
	Slightly louder than breathing	1		Yes	4
	As loud as talking	1 2 3		No	0
	Louder than talking	3		100000	
	Very loud, heard in adjacent		9.	If yes, how often does it occ	ur?
	rooms	4		Nearly every day	5
				3-4 times a week	4
3.	How often do you snore?			1-2 times a week	4
	Nearly every day	2		1-2 times a month	4
	3-4 times a week	2		Never or nearly never	0
	1-2 times a week	1			
	1-2 times a month	1	10.	Do you have high blood pre-	ssure?
	Never or nearly never	0		Yes	2
	AT A POST ACES ALL STATE STATE ACES ACES ACES ACES ACES ACES ACES ACE			No	0
4.	Has your snoring ever bothere	ed other	11	Do you have unusual leg mo	ovement at
pec	people?		3.55	night?	
	Yes	1		Yes	4
	No	0		No	Ó
-	Use severe settered that were			Don't know	2
٥.	Has anyone noticed that you o	quit			
	breathing during your sleep?		12.	Do you have unusual crawli	ng or tingling
	Yes 4			sensation in your legs that p	prevents you
	No	0	114-77	from falling asleep?	
_				Yes	4
6.	How often do you feel tired or	fatigued		No	0
	after your sleep?	100			
	Nearly every day	3 2 2	13.	Has your spouse complaine	d of your
	3-4 times a week	2		sleeping habits?	
	1-2 times a week	2		Yes	1
	1-2 times a month	1		No	0
	Never or nearly never	0			

Scoring: Total the scoring based on the patient's response. A score of 5 or higher indicates the possibility of a sleep disorder and your physician may order a sleep study.