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

PATIENT INFORMATION

NAME_____ DATE_____
First Middle Last

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE (Home)_____ (Work)_____ (Cell)_____

MARITAL STATUS: S M D W BIRTHDATE:_____ AGE:_____

SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____ ADDRESS:_____

SPOUSE:_____ BIRTHDATE:_____ SSN:_____

EMERGENCY CONTACT (FRIEND OR RELATIVE) NAME AND PHONE NUMBER:

_____

PHARMACY **NAME AND CITY**:_____

I HEREBY AUTHORIZE THE RELEASEOF MEDICAL INFORMATION FOR THE PROCESSING OF INSURANCE. I hereby assign all medical and 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_____

I HEREBY AUTHORIZE AND PERMIT Gulf Coast Surgical Associates to examine me and permit them to perform any necessary physical or laboratory tests as is deemed necessary to treat my illness.

Patient/Guardian Signature_____

INSURED PATIENTS: In order for us to bill promptly and correctly, you must provide us 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 payment of services rendered, including laboratory tests, medications and any other treatment. You are responsible for any deductible, coinsurance, non-covered and co-payment amounts as determined by your carrier.

Patient/Guardian Signature_____

UNINSUIRED PATIENTS: You are responsible for all charges incurred for services provided to you by Gulf Coast Surgical Associates. Payment arrangements are available to you. Your signature below is acceptance of responsibility of all charges.

Patient/Guardian Signature_____

PRIVACY RULE: The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical record and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer or the Practice Manager. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient/Guardian Printed Name:_____ **Patient/Guardian Signature:**_____ **Date:**_____

ANIL K. SINHA, MD, PA

NAME:_____ DATE OF BIRTH:_____

PAST MEDICAL HISTORY

BLOOD PRESSURE - HIGH LOW NORMAL
LUNG DISEASE- NO YES:_____
DIABETES- NO YES
OTHER-_____

PAST SURGICAL HISTORY

PLEASE LIST ALL SURGERIES WHICH REQUIRED ANESTHESIA:_____

_____

LIST ALL MEDICATIONS (INCLUDE OVER THE COUNTER) YOU CURRENTLY TAKE:

_____

_____

ALLERGIES TO MEDICATION:_____

DO YOU SMOKE _____ IF YES, HOW MUCH_____
DO YOU DRINK _____ IF YES, HOW MUCH_____

MAIN COMPLAINT (WHY ARE WE SEEING YOU TODAY?)

_____

FAMILY HISTORY (LIST ALL SERIOUS ILLNESSES-PARENTS/GRANDPARENTS/SIBLINGS):

_____

_____

_____

PRIMARY CARE PHYSICIAN:_____

WERE YOU REFERRED TO OUR OFFICE: YES NO
IF YES, WHOM MAY WE THANK?_____

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 _____

EMPLOYER NAME AND ADDRESS _____

BIRTHDATE _____ SS # _____

SECONDARY INSURANCE

NAME _____ ADDRESS _____

TELEPHONE _____ ID # _____ GROUP # _____

POLICY HOLDER NAME _____ ADDRESS _____

EMPLOYER NAME AND ADDRESS _____

BIRTHDATE _____ SS # _____

IN ACCORDANCE WITH THE PRIVACY ACT PLEASE LIST ANYONE THAT YOU WISH TO HAVE VERBAL OR WRITTEN INFORMATION REGARDING YOUR RECORDS.

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

PATIENT SIGNATURE/GUARDIAN _____

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:**_____ **Age:**_____

Weight:_____ **M/F:**_____

Please circle the number which best applies.

1. **Do you snore?**

Yes	1
No	0
Don't know	1

***If you snore*:**

2. **Your snoring is?**

I don't snore	0
Slightly louder than breathing	1
As loud as talking	2
Louder than talking	3
Very loud, heard in adjacent rooms	4

3. **How often do you snore?**

Nearly every day	2
3-4 times a week	2
1-2 times a week	1
1-2 times a month	1
Never or nearly never	0

4. **Has your snoring ever bothered other people?**

Yes	1
No	0

5. **Has anyone noticed that you quit breathing during your sleep?**

Yes	4
No	0

6. **How often do you feel tired or fatigued after your sleep?**

Nearly every day	3
3-4 times a week	2
1-2 times a week	2
1-2 times a month	1
Never or nearly never	0

7. **During your wake time, do you feel tired, fatigued or not up to par?**

Nearly every day	3
3-4 times a week	2
1-2 times a week	2
1-2 times a month	1
Never or nearly never	0

8. **Have you ever nodded off or fallen asleep while driving a vehicle?**

Yes	4
No	0

9. **If yes, how often does it occur?**

Nearly every day	5
3-4 times a week	4
1-2 times a week	4
1-2 times a month	4
Never or nearly never	0

10. **Do you have high blood pressure?**

Yes	2
No	0

11. **Do you have unusual leg movement at night?**

Yes	4
No	0
Don't know	2

12. **Do you have unusual crawling or tingling sensation in your legs that prevents you from falling asleep?**

Yes	4
No	0

13. **Has your spouse complained of your sleeping habits?**

Yes	1
No	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.*