LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	BIRTHDATE
ADDRESS		SEX	HOME PHONE	WORK PHONE
CITY	STATE		ZIP CODE	CELL PHONE
REFERRING PHYSICIAN NAME, PHONE #, AND ADDRESS:				
MARITAL STATUS	SPOUSE'S NAME	MOST RECENT HOSPITAL ADMISSION, NAME OF HOSPITAL AND DATE OF ADMISSION:		
PATIENT OCCUPATION	EMPLOYER	EMPLOYER ADDRESS AND PHONE #		
RESPONSIBLE PARTY & DOB:	**R.P. SOCIAL SECURITY #**	**RELATION**	**R.P. EMPLOYER AND PHONE #**	
PERSON TO NOTIFY IN EMERGENCY	RELATION	ADDRESS	PHONE #	
HOW ACCOUNT WILL BE PAID				
EMAIL ADDRESS		Yes / No	Send my confidential test results/appointment reminders by email.	

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
ADDRESS OF PRIMARY INS.	PHONE #	ADDRESS OF SECONDARY INS.	PHONE #
PRIMARY INSURANCE ID #		SECONDARY INSURANCE ID #	
GROUP #	**POLICY HOLDER'S NAME**	GROUP #	**POLICY HOLDER'S NAME**
POLICY HOLDER'S SSN #	POLICY HOLDER'S EMPLOYER:	POLICY HOLDER'S SSN #	POLICY HOLDER'S EMPLOYER:
POLICY HOLDER'S DOB		POLICY HOLDER'S DOB	

****PLEASE FILL OUT THIS FORM COMPLETLEY. OTHERWISE YOUR INSURANCE WILL NOT BE BILLED CORRECTLY.**

PHYSICIAN OFFICE STATEMENT
PLEASE READ THE FOLLOWING STATEMENTS CAREFULY BEFORE SIGNING

I/WE AGREE TO PAY ALL ATTORNEY'S FEES, COURT COSTS, FILING FEE'S INCLUDING CHARGES OR COMMISSIONS UP TO 50% THAT MAY BE ASSESSED TO US BY ANY COLLETION AGENCY RETAINED TO PURSUE THIS MATTER.
I/WE FURTHER AGREE TO PAY INTEREST ON ALL UNPAID BALANCES AT A RATE OF 1.5% PER MONTH (18% PER YEAR).
A SERVICE FEE OF $20.00 WILL BE CHARGED FOR RETURNED CHECKS.

IF ANY PORTION OF THIS BILL OR THE PROVIDERS SERVICE ARE DISPUTED, I AGREE TO SUBMIT MYSELF TO MEDIATION OR ARBITRATION AND WILL PAY THE COST IN DOING SO.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURESAND OTHERS PAY AT A PERCENTAGE OF THE CHARGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNT, CO-PAYS, OR ANY OTHER BALANCE NOT PAID BY SAID INSURANCE.

IN ORDER TO CONTROL COST OF SERVICES, THIS OFFICE REQUESTS THAT FEES FOR OFFICE VISITS BE PAID AT THE TIME OF SERVICE.

I/WE AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM SUBMITTED BY THE OFFICE.

I/WE REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO DR. GREGORY DUPONT.

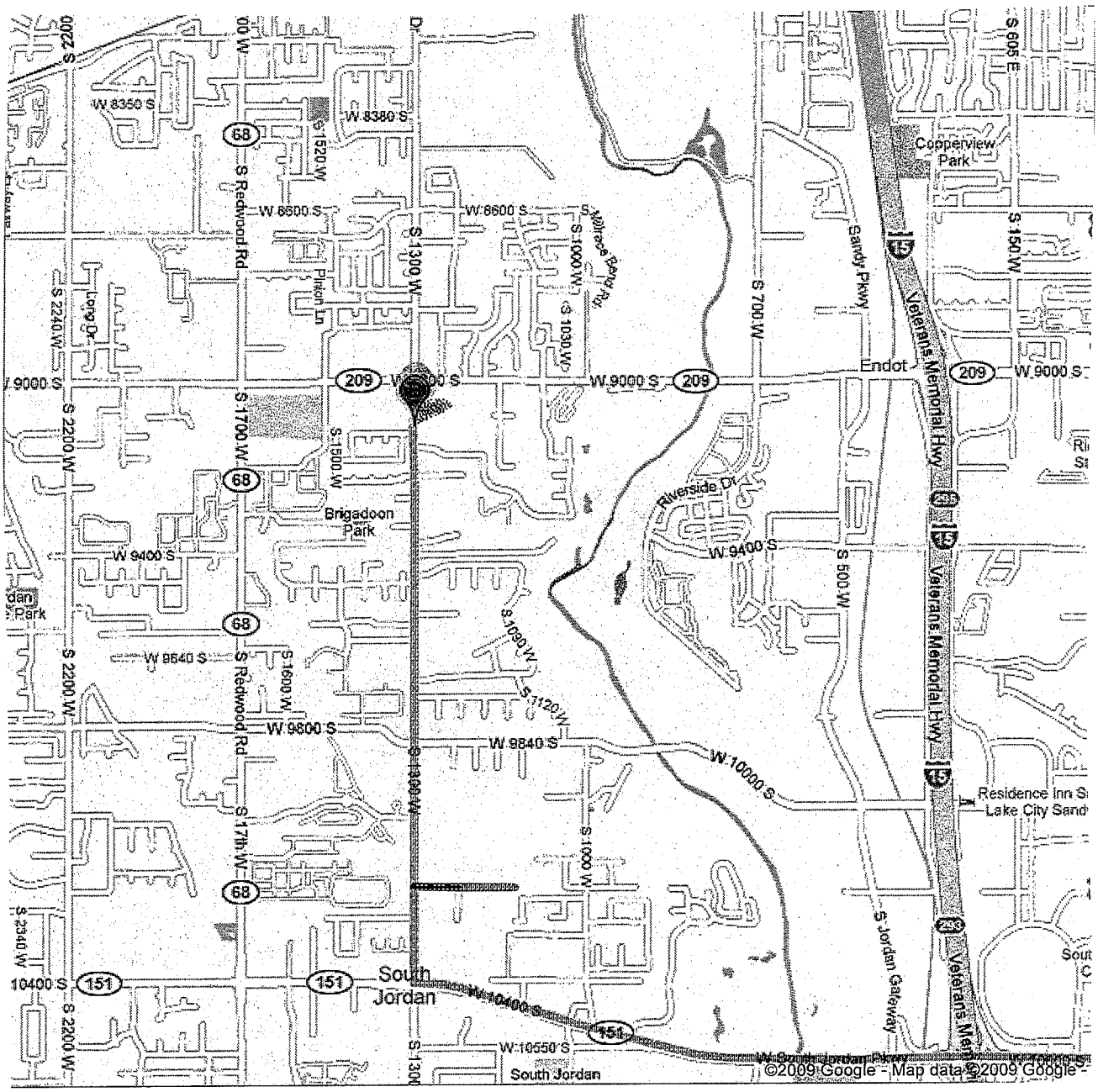
THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY)_____ **DATE**_____

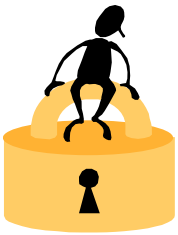
COPAYS ARE DUE AT TIME OF SERVICE

UTAH SLEEP & PULMONARY SPECIALISTS
9103 SOUTH 1300 WEST
SUITE 103
WEST JORDAN, UT 84088

From I-15 take the 9000 south exit and head west until you reach the light at 1300 west and then turn left (south). It will be on your left (the east side of the street) with Jordan Valley Dental on the corner. We are in suite 103 which is in the middle of the office strip.



PATIENT NAME: _____
(Please print name)



HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have had an opportunity to read, take a copy and make changes in writing of the Provider's "Notice of Privacy Practices" (HIPAA Notice). This is available in the office or online (www.utsleep.com) and explains when, where, and why my confidential health information may be used or shared. Dr. Gregory Dupont, Dr. Kathleen Pfeffer and their staff may use and share my confidential health information with others only as needed for treatment, payment of my bill or for healthcare operations (such as tests ordering or communicating with my doctor(s), unless otherwise specified.

_____ _____
Signature of patient/person authorized to consent **Date**

Please share my medical information with the following people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of patient/person authorized to consent **Date**

A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:
  _____
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):
  _____

Signature of Employee Completing Form: _____

Date Signed: _____

Utah Sleep & Pulmonary Specialists

Adult New Patient/General History

Name: _____ **Date:**_____

Notes: _____
_____
_____
_____
_____
_____
_____
_____
_____

Personal History: ___Lung disease ___Asthma ___Hay fever ___Sinusitis ___Heart Disease ___High blood pressure
___ Diabetes ___ Heart surgery ___Angina ___Thyroid Disease ___Pneumonia ___Bronchitis ___Depression/Anxiety
___Insomnia ___Tuberculosis ___Arthritis ___Kidney disease ___Seizures ___Anemia ___Cancer ___Gastric reflux
___Influenza vaccine ___Pneumonia vaccine ___ Blood clots in leg or lung
Childhood illnesses:_____

Drug Allergies? Yes / No	Type of reaction	Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries/Hospitalizations: _____
_____
_____

Work exposures: _____
_____

_____No medications, _____ List provided, _____List medications:_____
_____
_____
_____
_____
_____

Family History: ___Heart Disease ___Cancer ___Tuberculosis ___Diabetes ___Arthritis ___High blood pressure
___Stroke ___Asthma ___ Bronchitis ___Lung disease ___Kidney disease ___Seizures ___ Anemia
___Depression/Anxiety ___Sleep Disorder ___Blood clots in leg or lung
Other: _____

Social History: _____Smoking _____#Packs per day _____#Years smoked _____Quit? ____Years Quit
____Would like to quit? ____ Alcohol use (specify type/amount_____)
____Street Drug use ____ IV drug use _____Sex with men/women/both _____History of Abuse
____Married ____Single ____Divorced ____Regular exercise

Occupations (start with current and work backward, list years worked): _____
_____
_____
_____
_____

Utah Sleep & Pulmonary Specialists

Adult New Patient/Sleep History

Name: _____ Date: _____ Referred by: _____

Chief Complaint: _____ Age: _____ Date of Birth: _____

Length of complaint: _____

Time you get into bed:

Time you turn lights out:

Estimate how long it takes you to fall asleep:

Number of nighttime awakenings:

Length of time awake each time:

Final time awake in am:

Naps during the day:

Number of naps:

Length of naps:

Naps how many days of the week:

Estimated average hours of sleep per week including naps:

Do you ever have leg swelling? ____ Yes ____ No

Do you exercise on a regular basis? ____ Yes ____ No

Do you?
____ Snore ____ Stop breathing at night ____Wake up gasping
____ Snore worse if sleeping on your back:

Do you have any of the following:
____ Cateplexy (loss of muscle tone when angry/excited/scared)
____ Hypnagogic Hallucinations (vivid dreams/images upon falling asleep)
____ Sleep paralysis (wake up with temporary inability to move)

Weight Gain: ____ Yes ____ No
If yes, how much weight over what period of time:

Nasal Obstruction? _____

Heartburn? Describe: _____
_____

Energy Level: ____ Very low ____ Low ____ Good

Awake feeling: ____ Good ____ Tired ____ AM Headache

Driving Alertness: ____ Poor ____ Adequate ____ Good

Are you sleepy?
If so: ____ Mildly ____ Moderately ____ Severely

Is your sleep pattern the same on weekends? _____

What sleep aids have you tried (including prescription, over-the-counter, and herbal)?
_____
_____
_____

Stimulant use (what type and time of day used): _____
_____

Restless leg symptoms? (urge to move while laying quietly or sitting still) _____
_____

Triggering events for sleep problems: _____
_____

Pain or discomfort at night? (Describe) _____
_____

Other sleep complaints or abnormal sleep history (Describe) _____

Utah Sleep & Pulmonary Specialists
9103 South 1300 West, Suite 103
West Jordan, UT 84088
(801) 432-8690
www.utsleep.com

NAME: _____
Last First

TODAY'S DATE:____/____/____ **BIRTHDATE:**____/____/____ _____
Age

SEX: **M** **F** _____ _____ _____
Height Weight Neck Size

REFERRING DOCTOR: _____
Last First

ESS Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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 work out how they would affect you. Using the following key, circle the number which corresponds to the ***most appropriate number*** for each situation.

KEY

0 = would ***NEVER*** doze
1 = ***SLIGHT*** chance of dozing
2 = ***MODERATE*** chance of dozing
3 = ***HIGH*** chance of dozing

SITUATION	CHANCE OF DOZING (circle the number corresponding to the key above)			
Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting, inactive in a public place (e.g., a theater or a meeting)	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking with someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in the traffic	**0**	**1**	**2**	**3**

NAME: _____ **Date:** _____

REVIEW OF SYMPTOMS

PLEASE CHECK WHETHER PAST OR CURRENT PROBLEM. SKIP IF NOT A PROBLEM

	PAST	CURRENT
DECREASED HEARING	____	____
DIZZY OR FAINTING SPELLS	____	____
SEIZURES	____	____
STROKE	____	____
LOSS OF VISION	____	____
HEADACHES	____	____
MUSCLE WEAKNESS	____	____
NUMBNESS	____	____
SINUS TROUBLE	____	____
SORE THROATS	____	____
HAY FEVER	____	____
HOARSENESS	____	____
PNEUMONIA	____	____
FREQUENT BRONCHITIS	____	____
CHRONIC COUGH	____	____
ASTHMA/WHEEZING	____	____
PLEURISY	____	____
COUGHING UP BLOOD	____	____
DAILY SPUTUM	____	____
ASBESTOS EXPOSURE	____	____
COAL/SILICA EXPOSURE	____	____
TUBERCULOSIS	____	____
EXPOSURE TO TB	____	____
HEART ATTACK	____	____
SHORTNESS OF BREATH	____	____
-WITH EXERTION	____	____
-LYING FLAT	____	____
CHEST PAIN OR PRESSURE	____	____
HIGH BLOOD PRESSURE	____	____
HEART MURMUR	____	____
SWELLING IN ANKLES	____	____
SWELLING IN LEGS	____	____
BLOOD CLOTS	____	____
PALPITATIONS	____	____
SWOLLEN LYMPH NODES	____	____
EASY BRUISING	____	____
DIFFICULTY SLEEPING	____	____
DAYTIME SLEEPINESS	____	____
SNORING	____	____
RESTLESS LEGS	____	____

	PAST	CURRENT
LOSS OF APPETITE	____	____
INCREASED APPETITE	____	____
DIFFICULTY SWALLOWING	____	____
FREQUENT HEARTBURN	____	____
PERSISTENT NAUSEA	____	____
CHRONIC ABDOMINAL PAIN	____	____
FREQUENT DIARRHEA	____	____
FREQUENT CONSTIPATION	____	____
BLOOD IN STOOL	____	____
VOMITING BLOOD	____	____
HEMORRHOIDS	____	____
HEPATITIS/JAUNDICE	____	____
WEIGHT GAIN	____	____
WEIGHT LOSS	____	____
FATIGUE	____	____
ANEMIA	____	____
CANCER	____	____
DIABETES	____	____
ARTHRITIS	____	____
GOUT	____	____
RHEUMATIC FEVER	____	____
TOBACCO USE	____	____
PACKS PER DAY (AVG)	____	____
TOTAL YEARS SMOKED	____	____
USE OF ALCOHOL	____	____
STREET DRUGS	____	____
MARIJUANA USE	____	____
IV DRUG USE	____	____
GAY/LESBIAN/BI-SEXUAL	____	____
BLOOD TRANSFUSION	____	____
URINE OR KIDNEY INFECTIONS	____	____
KIDNEY STONES	____	____
BLOOD IN URINE	____	____
FREQUENT URINATION	____	____
INCREASED THIRST	____	____
LOSS OF URINE CONTROL	____	____
DEPRESSION	____	____
PHOBIAS/ANXIETY	____	____
HOPELESS FEELINGS	____	____
PHYSICAL/MENTAL ABUSE	____	____
SEXUAL ABUSE	____	____