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.

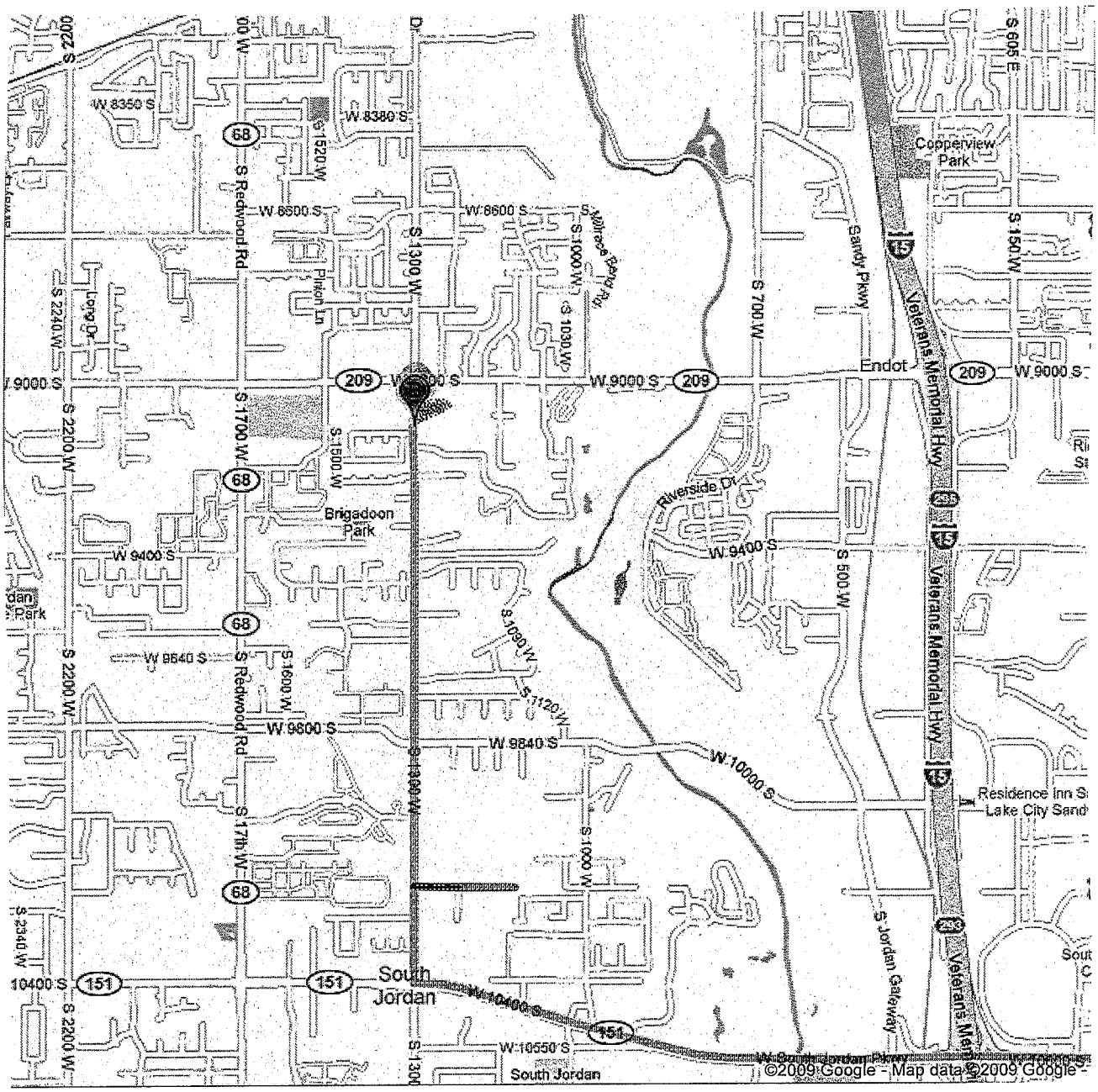
THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

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.



Pediatric Sleep Medicine

Utah Sleep & Pulmonary Specialists
9103 South 1300 West #103
West Jordan, Utah 84088

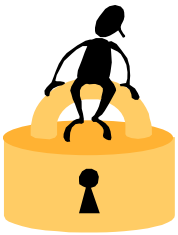
TWO-WEEK SLEEP DIARY

Name: ____________________________

1. Mark time child gets into bed with a down arrow ↓
2. Mark time child gets out of bed with an up arrow ↑
3. Shade in periods when child is asleep
4. Mark **W** if child was awakened by parent or alarm, or **S** if child awakened by self

Day:	Date:	Mid-Night	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm	Mid-Night
Fri	1-27				**Asleep**				↑ **W**					**Nap**		↑ **W**						↓				
Sat	**1-28**				**Awake S**					↑ **S**			***(Example: 2-day record)***										↓			

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
Kathleen Pfeffer, M.D.
9103 South 1300 West #103
West Jordan, Utah 84088
PH: (801) 432-8690 FX: (801) 432-8681
Pediatric Sleep Clinic

Pediatric Sleep/Pulmonary Questionnaire

Child's Name_____DOB:_____

Sex: Male Female (circle) Age:_____ School Grade_____

Parent/Guardian_____

Person Answering Questionnaire_____

Best phone number to use to discuss child/test results_____

Please describe your child's current sleep or pulmonary problem:_____
_____
_____
_____

When did the problem begin or you first noticed it? _____

1. Was your child premature? (circle) Yes No

2. Was he/she in the NICU? (circle) Yes No If so, how long?_____

3. Did your child require (circle): Oxygen CPAP Mechanical Ventilation

4. Was your child sent home on oxygen? Yes No If so, for how long?_____

5. Has your child been diagnosed with any of the following:

Seizures? Yes No

Head Injury? Yes No

Hydrocephalus? Yes No If so, does he/she have a shunt in place? Yes No

Cerebral Palsy? Yes No

Visual Hearing Speech Problems ? (please circle)

Other Neurological Problem or Diagnosis? Yes No
If so, please specify_____

Underlying genetic syndrome or diagnosis? Yes No
If yes, please specify_____

Recurrent Ear Infections (several/year)? Yes No

Recurrent Throat Infections/Tonsillitis (several/year)? Yes No

Recurrent Sinus Infections (several/year)? Yes No

Chronic congestion? Yes No

Hoarseness? Yes No

Headaches? Yes No

Bad breath? Yes No

Airway Abnormality (laryngomalacia, tracheomalacia, vocal cord dysfunction)? Yes No
If so, please specify_____

Thyroid Dysfunction? Yes No If so, please specify_____

Recent decrease or increase in weight? Yes No
If so, please specify_____

Asthma? Yes No

Chronic breathing disorder (wheezing, cough, noisy, fast , irregular or labored breathing)? Yes No
If so, please specify_____

RSV Infection? Yes No If so, when?_____

Heart Problems? Yes No If so, please specify?_____

Gastrointestinal Problems? (please circle) Reflux Constipation Diarrhea Difficulty eating by mouth

Eczema? Yes No

Allergies? Yes No
If yes, to what?_____
Has your child had allergy testing? Yes No

6. Has your child had any surgeries? (please circle)
PE tubes Adenoidectomy Tonsillectomy Sinus Nose Palate Teeth Airway Jaw
Heart Stomach (Nissan fundoplication, G-tube) Brain Other _____
If so, when?_____

7. Is your child on any medications? Yes No

Medication	Dose	Frequency	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Has your child ever been hospitalized? Yes No
Please explain_____
_____
_____

9. Does anyone in the family have snoring, obstructive sleep apnea or use CPAP/BiPAP? Yes No
Please specify_____

10. Does anyone in the family have restless leg syndrome? Yes No
If so, who?_____

11. Does anyone in the family have narcolepsy? Yes No
If so, who?_____

12. Does anyone in the family have asthma and/or allergies? Yes No
If so, who? _____

13. Please list **any** illnesses that run in the family, such as diabetes, hypertension, heart disease, thyroid disease, metabolic problems, psychiatric/mood disorders, seizures_____
_____
_____
_____

14. Is your child exposed to cigarette smoke? Yes No
If so, where? (please circle) at home in the car at a relative's home

15. Is your child around: (please circle) dogs cats birds?
If so, where?_____

16. Are there any other pets? Yes No
If yes, please specify_____

17. Has your child had any of the following tests?

	YES	NO	Date
Pulmonary Function Testing	____	____	_____
Sweat Test	____	____	_____
Immune studies	____	____	_____
Chest xray	____	____	_____
pH probe	____	____	_____
Upper GI	____	____	_____
Bronchosocpy	____	____	_____
CT scan of the chest or brain	____	____	_____
Other	____	____	_____

If your child has pulmonary or breathing concerns, please answer questions # 18-26

If your child has sleep concerns, please skip to questions # 27-70

18. Has your child had attack(s) of wheezing? Yes No
Please specify:_____
_____
_____

19. Does your child cough at night? Yes No; When ill or all the time?
Please specify_____
_____

20. Does your child have a wheeze or cough after exercise? Yes No
Please specify_____

21. Does your child have wheeze, chest tightness or cough that is worse in a certain season? Yes No
Please specify_____

22. Does your child have wheeze, chest tightness or cough during the winter inversion? Yes No

23. Do your child's colds 'go to the chest' or take more than 10 days to clear up? Yes No
Please specify_____

24. Are breathing or respiratory symptoms improved by medications such as albuterol, xopenex, inhaled steroids, prednisone, decadron, antibiotics)? Yes No
Please specify_____

25. Does your child seem to have more difficulty breathing <u>out</u> or breathing <u>in</u>? (please circle)

26. Does your child make a noise breathing in or breathing out? Yes No
Can you describe the noise?_____
_____

****

27. Does your child fall asleep alone in bed/crib? (please circle) Never Occasionally Almost Always

28. Does your child share a bedroom? Yes No
If yes, with whom?_____

29. Is there a regular "lights out" bedtime each night? Yes No
When is it? Weekdays_____Weekends_____

30. On average, how long does it take your child to fall asleep? _____

31. What do you think prevents your child from falling asleep (for instance: fears, loneliness, not sleepy, worries, etc)_____
_____

32. Does your child require any special routine or object to aid him/her in going to sleep (such as a pacifier, stuffed animal, special music, rocking, nursing, reading, etc)? Yes No
Please explain_____

33. Before going to bed does your child:		Never	Occasionally	Most of the Time
	watch TV	_____	_____	_____
	talk/text on the phone	_____	_____	_____
	use the computer	_____	_____	_____
	play video games	_____	_____	_____

34. What times does your child wake and get out of bed in the morning?
Weekdays_____ Weekends_____

35. Upon awakening, does your child seem: (please circle)
refreshed groggy still tired

36. Does your child take a nap? Yes No
How often?_____When?_____

37. Does he/she seem sleepy or tired during the day? Yes No

38. Does your child fall asleep during the day? Yes No
At school In the car Watching TV (please circle)
Other, please specify_____

39. Has the teacher been concerned about your child being sleepy, disruptive or inattentive at school?
Yes No

40. Does your child ever fall asleep suddenly or unexpectedly? Yes No

41. Does your child become weak or unsteady when excited, surprised or emotional (laughing or crying)? Yes No

42. Does your child ever seem to lose control of his/her arms (dropping something) or legs (stumbling) involuntarily? Yes No

43. Has your child ever complained of odd hallucinations when trying to fall asleep? Yes No

44. Has your child ever complained of an inability to move his/her body upon falling asleep or waking in the morning? Yes No

45. Does your child wet the bed? Yes No
If so, how frequently?_____
Has he/she ever been dry?_____

46. Does your child wake during the night? Yes No
How many times a night?_____
On average, about what time?_____
Is this consistent or does it vary?_____
How long is he/she up?_____

47. When your child wakes, does he/she appear to be: (please circle)
calm agitated confused violent

48. Does your child state he/she is afraid, but does not appear afraid? Yes No

49. Does he/she return to sleep quickly after his/her needs are met? Yes No

50. Does your child sleep walk? Yes No
How often?_____ Has he/she ever hurt themselves? _____

51. Does your child talk in her/his sleep? Yes No

52. Does your child have heavy or loud breathing? Yes No

53. Does your child awaken with snoring/snorting sounds? Yes No

54. Does your child breathe through his/her mouth during sleep? Yes No
During the Day? Yes No

55. Does your child snore at night? Yes No

56. How loud? (please circle)
Barely audible Near child's bed Outside of bedroom Disturbs household

57. Is snoring worse in a particular body position? Yes No
Specify_____

58. Has your child ever seemed to stop breathing during sleep? Yes No

59. Do you ever shake your child to start breathing? Yes No

60. Does your child sweat at night? Yes No

61. Has your child's lips turned blue or purple while asleep? Yes No

62. Is your child a restless sleeper (toss and turn, move all around the bed, pull covers off the bed, etc)
Yes No
63. Does your child sleep in unusual body positions? Yes No
Specify_____

64. Does your child rock their head or body from side to side at night? Yes No

65. Does your child complain of aching legs or the need to move his/her at bedtime? Yes No

66. Does your child's leg jerks while he/she is asleep? Yes No

67. Does your child have 'crawling sensations" in his/her legs during the day? Yes No

68. Does your child have a constant need to move his/her feet during the day/night? Yes No

69. Does your child have vivid, frightening dreams or nightmares? Yes No

70. Does your child ever awaken suddenly? Yes No
Explain_____

THANK YOU!!! Please don't forget to completed your "Sleep Log"