Brunswick Pulmonary and Sleep Medicine
Lawrence Davanzo, DO, FCCP
49 Veronica Ave, Somerset, NJ 08873
Phone# 732-246-3066 Fax# 732-246-3067

REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Chose office because/Referred to office by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other						
Other family members seen here: ___ Smoker ____ Non-smoker ___ Packs per day _____ Number of years						

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Pt. declined to specify

Race: ___ Asian ___ African American ___ Caucasian ___ Pt. declined to specify ___ Other: _____

Preferred Language: English___ Spanish ___ Other _____

Email address: _____

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here?	❑ Yes ❑ No		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

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Is this patient covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance	❑ Horizon	❑ United Healthcare	❑ Medicare	❑ Healthnet	❑ Aetna
❑ Oxford	❑ Cigna	❑ AmeriHealth	❑ GHI	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Brunswick Pulmonary And Sleep Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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LIST OF ACTIVE MEDICATIONS

(Please Print)

Prescription Name:	**Dosage:**	**Taken how often:**

Known Allergies:

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PRIVACY POLICY

(Please Read and Sign)

I understand that I have certain rights to privacy regarding my protected health insurance portability according to the accountability act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use my protected health information to carry out:

-**Treatment** (including direct or indirect treatment by other healthcare providers involved in my treatment)
- **Obtaining payment from third party payers** (i.e. my insurance company)
- **The day to day healthcare operation of the practice**

I have also been informed of my right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected

Print Name:_____

Signature: _____ **Date:** _____

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Lawrence Davanzo, DO, FCCP
49 Veronica Avenue; Suite 105
Somerset, NJ 08873 (phone: 732-246-3066)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____, authorize Brunswick Pulmonary & Sleep Medicine to obtain or release any of the following medical records regarding my health and/or medical management to/from any other providers, insurance carriers, or authorized agents.

Please check all that apply:

[ ] All Medical Records
[ ] Labs only
[ ] Radiology and/or Hospital Report(s)

[ ] Other:_____

This will *only* be used for the purpose of quality of care evaluations, reimbursement purposes, and/or any necessary treatment of medical care.

Signature: **Date :**

_____ _____

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Please place a check beside any of the following statements that are true for you.

_____ I have been told that I snore very loudly.
_____ Sometimes a person cannot sleep in the same room with me because he / she is bothered by my snoring.
_____My bed covers are very messy in the morning.
_____I am a very restless sleeper.
_____I have been told that I kick or poke my bed partner while I am asleep.
_____I have hallucinations or dreamlike images when I am not actually asleep but while falling asleep or waking up.
_____I sometimes awaken with a choking sensation.
_____I have been told that I stop breathing when I sleep.
_____I sometimes have felt paralyzed or unable to move when waking or falling asleep.
_____I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness.
_____I wake up from sleep with a feeling of muscle tension or tightness in my arms or chest.
_____I have awakened from sleep once or more having vomited or with heartburn.
_____When I wake during the night, I often have to get up and go to the bathroom.
_____I sweat a lot when I sleep.
_____I feel that the quality of my sleep is unsatisfactory.
_____I have been told that my legs twitch or jerk while I am sleeping.
_____Sometimes I wake up with a headache.
_____I have trouble falling asleep at night.
_____When I wake up during the night, I have trouble going back to sleep.
_____Some nights, I never get to sleep no matter how hard I try.
_____When I try to go to sleep, my mind races with many thoughts.
_____At night when I go to bed I do not feel sleepy.
_____When I try to fall asleep I become anxious or nervous.
_____When I try to fall asleep I worry about whether or not I can sleep.
_____When I try to fall asleep I often feel hungry or thirsty.
_____When I try to sleep I feel pain.
_____Pain often wakes me up or keeps me from going back to sleep.
_____I have a creeping, crawling sensation in my legs when I lie down to sleep.
_____When I do sleep, I feel that I sleep very well.
_____I am a very light sleeper. I am easily awakened by noises.
_____My sleep is disturbed because of bed partner.
_____Heat or cold disturbs my sleep.
_____Generally I get up in the middle of the night for a snack.
_____I have sometimes fallen asleep at very inappropriate times, such as while driving, eating or during a conversation.
_____I have sometimes been so sleepy that I became confused or lost track of the topic during a conversation.
_____I have had accidents or near-accidents when driving because I felt so sleepy.
_____When I have no plans or appointments the next day, I frequently go to bed late (compared with my usual bedtime).
_____I frequently do not feel sleepy at bedtime and stay up until it is late so that as a consequence I get too little sleep.

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 have affected you.

Use the following scale to choose **the most appropriate number** for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING (0–3)**
Sitting and reading	
Watching television	
Sitting inactive in a public place (i.e. a park or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alchohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 and up	Very sleepy and should seek medical advice