Florida Sinus & Snoring Specialists, LLC – Patient Information

Please Fill Out Form Completely

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government****

Salutation: Mr.___ Mrs.___ Ms.____Miss____ Dr.____ Marital Status: M ___ S___ D ___ W___ Other___

Patient Name: _____ _Date of Birth: _____ Age: _____ Sex: F____ M ____

Reason for visit: _____

Please check appropriate response:

* *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Caucasian_____

Native Hawaiian/Pacific Islander_____ Other Race____ Declined to answer _____

Please check appropriate response:

**Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____

Street City, State Zip

Patient's 2nd Address:_____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Patient's Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Pharmacy Name _____ Address_____ Tele# _____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____ ____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth:_____ID#_____Group#_____

Whom we may thank for referring you, check box below?

_____ Radio _____ Internet _____Insurance _____Facebook _____Instagram _____Zocdoc _____ Mailer Campaign

_____Email Campaign _____TV _____Website _____Health fair _____ Magazine _____Airport

Friend/Relative (Name) _____ Family Dr. / PCP (Name) _____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Florida Sinus & Snoring Specialists, LLC. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician/Physician Assistant and Florida Sinus & Snoring Specialists, LLC to photograph me for medically related documentation purposes. _____Yes _____No

Signature: _____ Date:_____

LEE M. MANDEL, M.D., F.A.C.S., F.A.R.S.
Diplomate, American Board of Otolaryngology
Diplomate, American Board of Facial Plastic and Reconstructive Surgery

Brigitte Shaw, M.M.S, PA-C Sameeksha Patil Ng-a-Kien, M.M.S., PA-C Eden Avni M.M.S., PA-C Beverly Gomez, M.S.P.A, PA-C

Florida Sinus & Snoring Specialists, LLC

1301 E. Broward Blvd., Suite 240, Ft. Lauderdale, Florida 33301, Tel: (954) 983-1211 * Fax: (954) 983-4190
950 S. Pine Island Road, Suite A-180, and Plantation, Florida 33324 Tel: (954) 587-4218 * Fax: (954) 587-4219

STOP BANG Questionnaire

Screening for Obstructive Sleep Apnea

Answer only the **STOP** portion of this questionnaire.

STOP		
Do you Snore loudly? (Louder than talking or loud enough to be heard though closed doors?	**YES**	**NO**
Do you often feel Tired, fatigued, or sleepy during the daytime?	**YES**	**NO**
Has anyone Observed you stop breathing during your sleep?	**YES**	**NO**
Do you have or are you being treated for high blood Pressure?	**YES**	**NO**

Patient Signature Date

BANG		
BMI more than 35kg/m^2	**YES**	**NO**
Age over 50 years old?	**YES**	**NO**
Neck Circumference > 15.75in. (40cm)?	**YES**	**NO**
Male Gender	**YES**	**NO**

TOTAL SCORE	

OSA RISK

≥ 3 yes answers: high-risk for OSA

< 3 yes answers: low risk for OSA

Office Use Only: BMI: _____ Neck Circumference: _____cm

LEE M. MANDEL, M.D., F.A.C.S., F.A.R.S.
Diplomate, American Board of Otolaryngology
Diplomate, American Board of Facial Plastic and Reconstructive Surgery

Brigitte Shaw, M.M.S, PA-C Sameeksha Patil Ng-a-Kien, M.M.S., PA-C Eden Avni M.M.S., PA-C Beverly Gomez, M.S.P.A, PA-C

Florida Sinus & Snoring Specialists, LLC

1301 E. Broward Blvd., Suite 240, Ft. Lauderdale, Florida 33301, Tel: (954) 983-1211 * Fax: (954) 983-4190
950 S. Pine Island Road, Suite A-180, and Plantation, Florida 33324 Tel: (954) 587-4218 * Fax: (954) 587-4219

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just 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 determine how they would have affected you. For each situation, decide whether or not you would have:

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

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

Interpretation:
0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Patient Signature Date