Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Pediatric Patient Information

Patient Name: _____Sex: _____
Last First MI

Date of Birth: _____ Age: _____ SSN: _____

Address: _____
City State Zip

Parent/Guardian Name: _____ Relationship: _____

Pharmacy: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Number: 1) _____ 2)_____

INSURANCE INFORMATION

Primary Insurance: _____

Policy/Member ID Number: _____Group Number: _____

Sponsor Information (If not patient): _____
Name DOB

Secondary Insurance (if applicable): _____

Policy/Member ID Number: _____Group Number: _____

Referring Physician: _____Family Physician: _____

Parent/Guardian Signature: _____ Date: _____

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Health and Sleep History

- Height: _____ Weight: _____
- What is your primary concern regarding your child's sleep?
  ( ) Trouble sleeping at night For how many months/years? _____
  ( ) Sleepiness during the day For how many months/years? _____
  ( ) Snoring For how many months/years? _____
  ( ) Odd/violent behaviors during sleep
  Explain: _____
  _____

  ( ) Other: _____

Please answer the following questions with Yes or No

- Does your child sleep on their back? _____
- Has your child ever sustained a brain concussion, head injury, or serious blow to the head? _____
- Does your child have seizures or other similar spells? _____
- Has your child ever seen another specialist for sleep disorders? _____
  If yes, when were they seen, by whom, and what was their diagnosis?
  _____
  _____
- Has your child ever had a sleep study before? _____
  If yes, when and where? _____
  What treatment, if any was recommended? _____
  Was the treatment effective? _____
- Is your child currently using the following? If yes, please provide pressures below
  ( ) CPAP: _____ cmH20
  ( ) BIPAP: _____ cmH20
  ( ) Oxygen: _____ LPM
  Who is the DME company that provided the above medical equipment?
  _____
- Please list any surgeries or hospitalizations your child has had: _____
  _____
  _____

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Please check all that apply to your child and write any additional conditions not listed in the space below:

	Heart Disease		Seizures		Heartburn
	Hiatal Hernia		Impotence		Bladder problems
	Kidney Disease		Headaches		Gout
	Vertigo/ Dizziness		Fibromyalgia		Asthma
	COPD		HX Pneumonia		HX Bronchitis
	Hemophilia		Syncope/Fainting		Meningitis
	Stomach Ulcer		Cancer: _____		Prostate Problems
	Arthritis		Hypertension		Dementia
	Bipolar		Depression		Anxiety
	PTSD		Back Pain		Low Blood Pressure
	Allergies		Muscle Disease		Heart Attack
	MS		ADHD		Renal Failure
	Restless Leg Syn.		Diabetes		Hypothyroidism
	Anemia		Head Injury		Emphysema
	High Cholesterol		Hyperlipidemia		Narcolepsy
	Sleep Apnea		Stroke/ TIA		CAD
	CHF		Cataracts		Chronic Congestion
	Neuropathy		Atrial Fibrillation		Herniated Disc
	IBS		Mitral Valve Disorder		Osteoporosis
	Visual Impairment		Alcoholism		Narcotic Use
	Insomnia		Migraines		Obesity

- Other:_____

  _____

- Please check any of the following symptoms that your child has had to an excessive degree:

( ) Fatigue	( ) Inability to concentrate
( ) Anxiety	( ) Depression
( ) Change in personality	( ) Family/home problems
( ) Memory impairment	( ) Irritability
( ) Loss of appetite	( ) Problems at school

Family History: Please list any major medical problems

Father:	
Mother:	
Children:	
Siblings:	
Other:	

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Medication Name	Dosage and Frequency	Prescribing Doctor

Allergies: _____

- Child's Employment Status: ( ) Employed ( ) Unemployed( ) Student
  If employed: ( ) My child's job requires driving a vehicle
  ( ) My child works with dangerous equipment or substances.
  ( ) My child is a shift worker on rotating shifts
  ( ) My child is a permanent or long term night shift worker.

- My child lives with the following:
  ( ) Both parents ( ) Father ( ) Mother ( ) Grandparents ( ) Other

Please list siblings with their ages:
_____

- Where does your child sleep? _____
- Grade level in school? _____ Special education? _____
- Does your child use alcohol, tobacco, or caffeine? If yes, please describe:
  _____

- What is your child's current weight? _____ Height? _____ Neck? _____

Is your child on a diet? _____ If yes, what kind? _____
Does you child exercise? _____ If yes, how often and what type? _____
_____
Has your child's weight changed drastically lately? _____ If yes, what was the gain or loss and over what period of time? _____

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Sleep Hygiene

On school/work days, what time does your child?
Go to bed? _____ am/pm Wake up? _____ am/pm
On weekends/days off, what time does your child?
Go to bed? _____ am/pm Wake up? _____ am/pm
Does your child take naps during the day? _____ If yes, how many? _____
Are the naps refreshing? _____ How long do they last? _____
Does your child refuse to go to bed at night? _____
Does you child have access to any of the following items in his/her bedroom?
( ) TV ( ) Video games ( ) Computer ( ) Phone
Does your child share a room with another person or pet? ____
If yes, specify? _____

Insomnia

Does your child have difficulty falling asleep? YES NO
If yes, how long does it take? _____
Does your child awaken during the night? YES NO
If yes, how many times a night? _____ Why do they wake up? _____
_____
Does your child have extended periods of wakefulness during the night? YES NO
Does your child awaken too early in the morning and stay awake? YES NO

Parasomnia

Does your child have intense nightmares? YES NO. If yes, times per week _____
Does your child walk in their sleep? YES NO. If yes, times per week _____
Does your child grind or clinch their teeth at night? YES NO
Does your child wet the bed at night? YES NO. If yes, times per week _____
Does your child talk in their sleep? YES NO. If yes, times per week _____
Does your child rock or bang their head in their sleep? YES NO

Hypersomnia

Has your child ever been injured because of falling asleep during the day? YES NO
Has your child had an accident or near miss due to falling asleep while driving? YES NO
Has your child ever fallen asleep during normal daytime activities? YES NO
If yes, please describe: _____
_____

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

RLS/PLMS

Does your child awaken at night by kicking their legs? YES NO
If yes, how often? _____

Does your child move excessively during the night? YES NO
Does your child ever complain of a funny feeling in his/her legs that makes it difficult to fall asleep? YES NO. If yes, how often? _____

OSA

Does your child awaken with a sore throat? YES NO
If yes: Rarely Occasionally Frequently
Does your child awaken with nasal congestion? YES NO
If yes: Rarely Occasionally Frequently
Does your child awaken with dry mouth? YES NO
If yes: Rarely Occasionally Frequently
Have you ever heard your child stop breathing in their sleep? YES NO
If yes: Rarely Occasionally Frequently
Does your child ever wake up gasping for air? YES NO
If yes: Rarely Occasionally Frequently
Does your child have a headache when they wake up in the morning? YES NO
If yes: Rarely Occasionally Frequently
Does your child have problems with memory and/or concentration? YES NO
If yes: Rarely Occasionally Frequently
Does your child feel tired after sleeping through the night? YES NO
If yes: Rarely Occasionally Frequently
Does your child have heartburn at night? YES NO
If yes: Rarely Occasionally Frequently
Does your child have night sweats? YES NO
If yes: Rarely Occasionally Frequently
Does your child wake up to use the restroom at night? ____. If yes, how many times? ___
Does your child snore? YES NO
If yes, please select one of the following:
___Heard only if you listen close to their face
___ Heard inside the room
___ Heard outside the bedroom with the door open
___ Heard outside the bedroom with the door closed

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Narcolepsy

Has your child ever displayed sudden muscle weakness when they laughed, were angry, or surprised? YES NO. If yes, describe: _____

Has your child ever expressed vivid dreams as they were falling asleep or waking up? YES NO. If yes, describe: _____

Has your child ever been unable to move or felt paralyzed as they were falling asleep or waking up? YES NO. If yes, describe: _____

Adolescent Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation based on your usual daily activities. Circle the number that applies to you.

Scale: 0= No chance of dozing 1=Struggles to stay awake 2= Fallen asleep 3= Both struggles to stay awake and has fallen asleep	Chance of Dozing
Face to face conversation with someone	0 1 2 3
Watching TV or listening to the radio	0 1 2 3
As a passenger in a car for an hour without stopping	0 1 2 3
Attending a performance(movie, concert, play)	0 1 2 3
During a test	0 1 2 3
In a class at school	0 1 2 3
While doing homework on a computer	0 1 2 3
Playing video games	0 1 2 3
Subtotal Epworth Score:	+ + + =
Epworth Score	

Thank you for choosing the Sleep Disorder Center of Panama City!!

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Patient Name: _____ Date: _____

Release of Information

I hereby authorize the SLEEP DISORDER CENTER OF PANAMA CITY to release my information to any medical provider such as physicians, medical equipment companies, or hospitals as well as to any insurance company or responsible party. This information may include diagnosis, records of treatment, and any procedures or services rendered. In addition to the above release, I authorize the SLEEP DISORDER CENTER OF PANAMA CITY to release any information to the following person: _____

Name

Assignment of Benefits

I authorize and request payments of insurance benefits paid directly to SLEEP DISORDER CENTER OF PANAMA CITY. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to be released to agents when information is needed to determine benefits. I understand that I am fully responsible for all deductibles, coinsurances, and disallowed items. I also understand that if a particular item or service rendered if deemed "not reasonable and necessary" under Medicare standards and the claim is denied then I am fully responsible.

Consent to Treat

I authorize SLEEP DISORDER CENTER OF PANAMA CITY and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf. I understand that in the even of a medical emergency, my physician will be contacted. If immediate medical care is requires, 911 will be summoned and I will be transported to Bay Medical Sacred Heart. I understand that there have been no guarantees made to the results of the test(s)/ procedure(s).

Consent for Photographs/Video Recording

I consent to be photographed and video taped for my sleep study. I have been shown the location of the camera and the technician has explained that the camera will be turned on and recording stared prior to the study and turned off at the end of my study.

Cancellation Policy

We ask that you call us no later than 24 hours in advance if you need to cancel or change your sleep study. If you fail to comply you will be charged a cancellation fee of $150.

I have read all of the information provided to me by the SLEEP DISORDER CENTER OF PANAMA CITY. By signing this document I agree to and understand all of the information listed above.

_____ _____

Parent/Guardian Signature Witness Signature

Sleep Disorder Center
of Panama City
Jesus M. Ramirez, M.D.
502 N. MacArthur Avenue, Panama City, FL 32401 • Office: 850.769.1797 • Fax: 850.215.2185 • www.sdcpc.com

Patient Name: _____ Date: _____

Acknowledgement of Receipt
of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of the SLEEP DISORDER CENTER OF PANAMA CITY's Notice of Privacy Practices.

_____ _____
Parent/Guardian Signature Date Witness Signature Date

_____ _____
Personal Representative Date Personal Representative (print)

****For Office Use Only****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ The patient refused to sign

_____ We were unable to communicate with the patient

_____An emergency situation prevented us from obtaining an acknowledgment

_____ Other: _____

_____ _____
Employee Signature Date