



Pinehurst Medical Clinic

Location: Pinehurst Medical Clinic Sleep Disorder Center
245 Page Road
Pinehurst, NC 28374

Dear New Patient of Pinehurst Medical Clinic Sleep Disorder Center,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic's Sleep Disorder Center. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 15 minutes prior to the scheduled time of your appointment to avoid delays.
2. Bring your medical insurance card(s) and medications with you on the day of your appointment. To find a list of PMC's contracted payers or to review additional insurance information, please visit pinehurstmedical.com/resources-category/insurance
3. Complete your new patient paperwork before coming to your appointment. If you need a paper copy mailed to you, please call (910) 695-2161 to make this request. Please allow at least 2 business days for your request to be processed, and an additional 5-7 business days to receive a paper copy in the mail.
4. If previous medical records are needed our office may contact you to make arrangements to obtain records.
5. If you are a new patient being seen for Sleep Medicine and have seen a previous doctor for sleep issues, please bring all sleep records and studies you have had in the past to your appointment. You can also have these records faxed prior to your appointment by sending them to (919) 292-1205.
6. Once you've established care, for urgent needs after hours, please call the office and follow the instructions to reach the provider on call.

*Pinehurst Medical Clinic Pulmonology & Sleep Medicine kindly ask you and anyone coming with you to your appointment to **refrain** from wearing scented lotions, perfumes, and/or cologne as many of our patients are sensitive to these products. If you or any persons with you do not adhere to this policy, you may be asked to reschedule.*

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Sleep Medicine
(919) 292-1201

REGISTRATION FORM
PATIENT INFORMATION

Patient's Name:		
Address:		
City:	State:	Zip Code:
Home Phone:		
Mobile Phone:		Other Phone:
Patient e-mail:		
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown		
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student <input type="checkbox"/> Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	State:	Zip Code:
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	Effective Date – From:
Subscriber Name:	Patient's Relationship to Insured:
Subscriber SSN:	Subscriber's DOB:
Subscriber Employer:	Subscriber's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female



Please Arrive 15 Minutes Before Your Scheduled Appointment Time

Pinehurst Medical Clinic Sleep Medicine Questionnaire

Name: _____ Date: _____

Referring Doctor: _____

Why are you seeing a sleep specialist: _____

Please help us find out about you by filling out the "Patient" side of this form

PATIENT

CLINICIAN

When did your sleep issues begin? _____

Any trouble sleeping as a child or teenager? [] Yes [] No

If you have tried any sleep medications which ones?

Are you currently using a sleep aid and which one? _____

Tell us about your sleep schedule:

What is your weekday bedtime? _____ wake up? _____
weekend bedtime? _____ wake up? _____

How long does it take for you to fall asleep? _____ minutes _____ hrs.

What time do you eat dinner? _____

What snacks/drinks do you typically consume after dinner?

What do you do after dinner? _____

Do you do any of the following activities in bed before bedtime?

Circle all that apply: Read Watch TV Play Video Games

Talk on the Phone Use Cell Phone, Tablet, or Computer

How many times do you wake up in the middle of the night? _____

able to fall back to sleep easily? [] Yes [] No [] Not always

How often do you need to get up to urinate during sleep? _____

What do you do when you are unable to sleep? _____

Do you work outside the home? [] Yes [] No

If yes, what are your hours? _____

Do you work weekends? [] Yes [] No Shift Work? 1st 2nd 3rd

Retired? [] Yes [] No

Disabled? [] Yes [] No

BMI>35

Age>50

Neck:

Gender:

Mallampati:

Do you take daytime naps? Yes No

How many per week? _____

How long do they last? _____

What time of the day? _____

Are the naps refreshing? Yes No

Do you doze (unintentional falling asleep) in the afternoon or evening?

Yes No

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Do you ever experience restlessness in your legs before bedtime?

No Yes: how many days per week? _____

If yes, does it disrupt your sleep? Yes No

Do you move or kick your legs while sleeping? (*Bed partner complains*)

Yes No Don't know

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Currently smoking?

Yes No

Do you drink alcohol beverages routinely at night?

Yes No

If yes, how many? _____

Do you drink caffeinated beverages (coffee, tea, soda)? Yes No

How many before 6pm? _____ How many after 6pm? _____

Do you drink any type of energy drinks?

Yes No

If yes, how many and what times? _____

If you use any recreational drugs, please list: _____

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Have you ever felt the sudden loss of strength (arms/legs) in response to emotional experiences?

Yes No

Have you ever felt paralyzed when you first wake up or when falling asleep?

Yes No

Do you ever have vivid or menacing visions while you are falling asleep?

Yes No

Do you walk in your sleep?

Yes No

Talk in your sleep?

Yes No

Do you have nightmares?

Yes No

Do you ever accidentally urinate in bed?

Yes No

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Are you sleepy or tired during the day? Yes No

How many days of the week? _____

When did it start _____ weeks _____ months _____ years

Is it worsening? Yes No

Have you had close calls or accidents when driving due to sleepiness?

Yes No

Have you had any issues with concentration or memory loss?

Yes No

Please rate your chances of **falling asleep** in the following situations using the scale below:

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

- _____ Sitting and reading
- _____ Watching television
- _____ Sitting inactive in a public place
- _____ While a passenger in a car without a break
- _____ Laying down to rest in the afternoon when circumstances permit
- _____ Sitting and talking to someone
- _____ Sitting quietly after lunch (without alcohol)
- _____ In a car, while stopped in traffic for a few minutes

Rate the severity of your daytime **fatigue**:

- 0---1----2---3--4-5---6--7--8---9--10

None Moderate Severe

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Have you been diagnosed with sleep apnea? Yes No
If yes, are you on CPAP therapy? Yes No
If no, please answer the following:

Do you snore? Yes No
 If yes, is it loud? Yes No
 Is it getting worse? Yes No
 Do you snore on your back? Yes No In a chair? Yes No
 NoDo you gasp or choke during sleep? Yes No
 Has anyone ever noticed you stop breathing during sleep?
 Yes No
 Do you wake with a dry mouth? Yes No Sometimes
 headache? Yes No Sometimes

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Health Questionnaire:

Allergies: _____ None

Please list any current or past illnesses/medical conditions you have been treated for:

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Please list all current medications: *If PMC patient, this is not needed.*

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Pinehurst Medical Clinic Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that apply:

- All of my medical information
- Information necessary to schedule appointments for me
- Lab or test results
- Information necessary to provide, call in or pick up prescriptions for me
- Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at Pinehurst Medical Clinic, unless and until I notify Pinehurst Medical Clinic in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to patient: _____

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are \$75 for a new patient office visit, \$25 for an established patient office visit, and \$25-\$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9392. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information:
<https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/>
14. Failure to pay a balance due promptly may result in one or more of the following:
 - a. Your account may be referred to a collection agency,
 - b. Your past due status may be reported to the applicable credit bureaus,
 - c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327-3159.



Pinehurst Medical Clinic

Access Your Health Information Online

Where you need it, when you need it.

Powered By FollowMyHealth

An all-in-one personal health record & patient portal that lets you access your health information online & on the go!



View test & lab results



Receive email care reminders



Send & receive secure online messages



Request appointments



Request Rx refills



Set up proxy accounts for children & dependent adults

To get started with a new account, give receptionist your email. To log in to an existing account, scan below.



Questions?

Call (910) 235-3380 or email fmhsupport@pinehurstmedical.com