132 A Eldridge Road, Sugarland, TX 77478. Tel: 832.999.4380. Fax:281.783.2832

ASCENT
sleep&weight

Dear Parent/Guardian,

In order to expedite your visit with us, please complete the New Patient Registration form below.

Please check with your insurance company to see if PRIOR AUTHORIZATION is needed for this appointment or procedure. If your insurance requires a referral, please ensure your referral has been processed prior to this appointment or procedure.

All copayments are due at the time of service. If you have any questions or are unsure whether you have a copay you may call and verify this information with your insurance company.

Due to the wait involved in scheduling appointments, we require a 48-hr notice of any appointment cancellations.

Please have reports of any sleep studies previously performed for your child at hand.

Kindly note that Child must be present for all clinic visits.

Thank you in advance for your consideration.

Sincerely,

Dr. Olatunji Olaoye

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ASCENT sleep&weight

Patient No: _____ **File No:** _____

PATIENT INFORMATION

ASCENT SLEEP & WEIGHT

PATIENT NAME (PLEASE PRINT)	SSN #	SEX □M □F	BIRTH DATE
STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE #
E-MAIL ADDRESS	CELL PHONE#		BUSINESS PHONE # EXT.
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT		
RACE	ETHNICITY		LANGUAGE PREFERENCE

I GIVE ASCENT SLEEP & WEIGHT STAFF PERMISSION TO LEAVE MESSAGES REGARDING MY MEDICAL CARE AND/ OR APPOINTMENT CONFIRMATION INFORMATION ON (CHECK ALL THAT APPLY): □ E-MAIL □ CELL PHONE □ HOME PHONE	SPOUSE OR PARENT'S NAME

FINANCIALLY RESPONSIBLE PARTY'S NAME (IF DIFFERENT FROM PATIENT)	FINANCIALLY RESPONSIBLE PARTY'S ADDRESS (IF DIFFERENT FROM PATIENT)
REFERRING PHYSICIAN	**ADDRESS/ CITY/ STATE/ ZIP CODE (IF KNOWN)**
PRIMARY CARE PHYSICIAN	**ADDRESS/ CITY/ STATE/ ZIP CODE (IF KNOWN)**
PHARMACY NAME AND PHONE NUMBER	**ADDRESS/ CITY/ STATE/ ZIP CODE (IF KNOWN)**
REASON FOR VISIT	

How Did You Hear About Us?

□Doctor's Referral □Friend □Hospital □Close to Home/Work □Online □Family Member

□Other _____

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INSURANCE INFORMATION — Please Provide Insurance Card(s) for copying

#1 PRIMARY INSURANCE — *Insurance card not available□*

Policy Holder Name (Name listed on Policy Card):

First: _____ Middle: _____ Last: _____

Policy Holder's _____/_____/_____ _____ Is this person a patient of Ascent S&W □Yes □No
Date of Birth Policy Holder SSN

Relationship to Patient: □Self □Spouse □Child □Parent □Other _____

Insurance Company Name: _____ Contact No. (_____)_____

Policy ID #: _____ Group # _____

_____ _____
Claims Mailing Address City State Zip

Employer Name: _____ Employer Telephone (_____)_____

Co-Payment: $

#2 SECONDARY INSURANCE — *Insurance card not available□*

Policy Holder Name (Name listed on Policy Card):

First: _____ Middle: _____ Last: _____

Policy Holder's _____/_____/_____ _____ Is this person a patient of Ascent S&W □Yes □No
Date of Birth Policy Holder SSN

Relationship to Patient: □Self □Spouse □Child □Parent □Other _____

Insurance Company Name: _____ Contact No. (_____)_____

Policy ID #: _____ Group # _____

_____ _____
Claims Mailing Address City State Zip

Employer Name: _____ Employer Telephone (_____)_____

Co-Payment: $

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.
PLEASE INCLUDE ALL NECESSARY INSURANCE FORMS AT THIS TIME.
INSURANCE ASSIGNMENT OF BENEFITS.

Signature	**DATE**

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I certify that the above information is true. I authorize my insurance benefits be paid directly to provider ASCENT HEALTHCARE SOLUTIONS. I understand that I am financially responsible for any balance. I also authorize Ascent Healthcare Solutions or insurance company to release any information required to process my claims. Patients are responsible for the payment of co-pays, co-insurance, deductible and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. Patients may incur and are responsible for the payment of additional charges at the discretion of Ascent Healthcare Solutions and all such charges will be duly itemized and explained to the patient. Please be advised that it remains the patient's responsibility to let us know at the time of service if the insurance policy has changed or has been termed for any reason. If insurance policy has been termed at time of service for any reason, patient will be financially responsible for 100% of the charges. I agree that I am financially responsible for charges incurred that are not covered by my insurance.

---------- office use only below ----------

Reviewed by: _____

Child's Name: _____ **Date of Appointment:** _____

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Child's Name: _____ **Today's Date:** _____

ASCENT SLEEP & WEIGHT **NEW PATIENT VISIT**

It is important that we have complete and accurate information about you and your medical condition(s). Please read instructions carefully and complete the following:

PHYSICIAN INFORMATION

Please complete the following information for all physicians/health care providers you have seen within the past 5 years (starting with your Primary Care Provider):

Name	City	Specialty or Problem	Approximate dates seen	May we send reports to them. Please indicate Yes or No
		Primary Care Provider		

Additional Physician(s) you would like reports sent to:

_____

MEDICATION(S)

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications? □ No □ Yes
If yes, list medications below:

NAME OF MEDICATION	DOSE (I.E., MGS)	HOW OFTEN TAKEN

Are there other medications you have recently used? □ No □ Yes If yes, list medications below:

_____

_____

Do you have allergic reaction to any food? (please list food and reaction)

_____

_____

Have you had hives, skin rash, breathing problems or other allergic reaction to medication? □ No □ Yes If yes, list below:

_____

_____

Are there other medications you would prefer not to take because of prior side effects? □No □ Yes If yes, list below:

_____

_____

Does your child have a learning disorder or IEP? □ No □ Yes: If yes, please describe:

_____

_____

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Childs Name: _____ **Date of Appointment:** _____

PAST MEDICAL HISTORY

Have you EVER had any of the following:		**DESCRIBE:**
Anesthesia complications	☐ No ☐ Yes	
Anxiety, depression, mental illness	☐ No ☐ Yes	
Blood problems (bleeding, anemia, high or low white count)	☐ No ☐ Yes	
Diabetes	☐ No ☐ Yes	
Stroke or TIA	☐ No ☐ Yes	
Treatment for alcohol or drug abuse	☐ No ☐ Yes	
Concerns regarding ADD/ADHD or other learning disorder	☐ No ☐ Yes	

Indicate whether you have EVER had a medical problem and/or surgical problem related to each of the following by placing a check in the appropriate box(es). Describe the problem, type of surgery and approximate dates. CIRCLE the appropriate choice when multiple choices are listed in a question.

PROBLEM:		**DESCRIBE:**
Eyes (cataracts, glaucoma)	☐ No ☐ Medical ☐ Surgical	
Ears, nose sinuses, tonsils	☐ No ☐ Medical ☐ Surgical	
Thyroid, parathyroid glands	☐ No ☐ Medical ☐ Surgical	
Heart valves, heart rhythm, heart failure	☐ No ☐ Medical ☐ Surgical	
Coronary (heart), arteries (angina, heart attack)	☐ No ☐ Medical ☐ Surgical	
Arteries (aorta, arteries to head, arms, legs)	☐ No ☐ Medical ☐ Surgical	
Veins, blood clots in veins	☐ No ☐ Medical ☐ Surgical	
Lungs	☐ No ☐ Medical ☐ Surgical	
Esophagus or stomach (ulcer)	☐ No ☐ Medical ☐ Surgical	
Bowel (small or large intestine)	☐ No ☐ Medical ☐ Surgical	
Appendix	☐ No ☐ Medical ☐ Surgical	
Liver or gall bladder	☐ No ☐ Medical ☐ Surgical	
Hernia	☐ No ☐ Medical ☐ Surgical	
Kidneys, bladder	☐ No ☐ Medical ☐ Surgical	
Bones, joints, muscles	☐ No ☐ Medical ☐ Surgical	
Back, neck, spine	☐ No ☐ Medical ☐ Surgical	
Brain	☐ No ☐ Medical ☐ Surgical	
Skin	☐ No ☐ Medical ☐ Surgical	
Breasts	☐ No ☐ Medical ☐ Surgical	
Uterus, tubes, ovaries	☐ No ☐ Medical ☐ Surgical	
Prostate, penis, testes, vasectomy	☐ No ☐ Medical ☐ Surgical	
Other – Describe	☐ No ☐ Medical ☐ Surgical	

DOES YOUR CHILD:		**DESCRIBE:**
Breathe out of mouth or nose during sleep?	☐ mouth ☐ nose ☐ both	
Snore?	☐ No ☐ Yes	
Breathe loudly during sleep?	☐ No ☐ Yes	
Kick legs rhythmically (every 5-90 seconds) during sleep?	☐ No ☐ Yes	
Sweat during sleep?	☐ No ☐ Yes	
Sleep in odd positions? (head hanging off the bed, head stretched backwards, on all fours, knees up to chest, on multiple pillows)?	☐ No ☐ Yes	
Act restless during sleep?	☐ No ☐ Yes	
Complain of uncomfortable legs at night or growing pains?	☐ No ☐ Yes	
Have problems with bed-wetting? (if no, was dry at age ___)	☐ No ☐ Yes	
Fall asleep easily in a car or on the bus (circle which)?	☐ No ☐ Yes	
Fall asleep during school?	☐ No ☐ Yes	

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Childs Name: _____ **Date of Appointment:** _____

PAST SOCIAL HISTORY

(please check) Parent Marital Status: □ Single □ Married □ Widowed □ Divorced □ Other

Does your child live with (circle all that apply) Mother Father Step-mother Step-father Other

Please indicate if the following applies:		Describe:
Do you exercise?	□ No □ Yes	
Do you consume caffeinated beverages?	□ No □ Yes	
Is there any smoking in the household?	□ No □ Yes	

FAMILY HISTORY

Indicate if any of your immediate family members such as mother, father, brothers, sisters or children have any medical conditions.

	Alive or Deceased	**Age(s)**	**Describe:**
Father	□ Alive □ Deceased		
Mother	□ Alive □ Deceased		
Brother(s)	□ Alive □ Deceased		
Sister(s)	□ Alive □ Deceased		

BIRTH HISTORY

Was your child: □ full-term □ pre-mature (_____number weeks)

□ Vaginal delivery □ C-section _____ birth weight Went home with mother? □ No □ Yes

Walking/talking milestones: □ on time □ delayed

REVIEW OF SYSTEMS

Indicate whether you have experienced the following symptoms DURING RECENT WEEKS by checking the "no" or "yes" box for each question.

Skin rash, sore, excessive bruising or change of a mole	□ No □ Yes	
Excessive thirst or urination	□ No □ Yes	
Significant headaches	□ No □ Yes	
Double or blurred vision, cataracts, glaucoma	□ No □ Yes	
Diminished hearing, dizziness, hoarseness, sinus problem	□ No □ Yes	
Cough, shortness of breath, wheezing, asthma	□ No □ Yes	
Coughing up sputum or blood	□ No □ Yes	
Blackouts or loss of consciousness	□ No □ Yes	
Chest pain, pressure, rapid or irregular heartbeats	□ No □ Yes	
Awakening at night short of breath	□ No □ Yes	
Abnormal swelling in legs or feet	□ No □ Yes	
Pain in calves when you walk	□ No □ Yes	
Difficulty swallowing, heartburn, nausea, vomiting	□ No □ Yes	
Significant problems with constipation, diarrhea	□ No □ Yes	
Blood in bowel movements	□ No □ Yes	
Difficulty starting urinary stream or completely emptying bladder	□ No □ Yes	
Leaking urine	□ No □ Yes	
Burning or pain when urinating	□ No □ Yes	

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Childs Name: _____ **Date of Appointment:** _____

Fever, large lymph nodes	□ No □ Yes	
At risk for HIV or AIDS	□ No □ Yes	
Weight loss or gain of more than 10 pounds over 6 months	□ No □ Yes	
Experiencing an unusually stressful situation	□ No □ Yes	
Problems falling asleep, staying asleep, sleep apnea, snoring	□ No □ Yes	(Please circle which symptom)

For medical team use only:

Signature of Patient / Patient's Authorized Representative: _____

Today's Date: _____

Thank you!

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I certify that I am hereby made aware of Ascent Sleep & Weight's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Ascent Sleep & Weight operations. The Notice also describes my rights and Ascent Sleep & Weight's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available at the reception desk of Ascent Sleep & Weight and I may also request that a copy be mailed to me by emailing sleepweight@outlook.com or calling 832.999.4380.

Ascent Sleep & Weight reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me or by asking for one at the time of my next appointment.

Signature of Patient / Patient's Authorized Representative: _____

Name of Patient's Authorized Representative: _____

_____

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ASCENT
sleep&weight

AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize Ascent Sleep & Weight and any of its employees to use or disclose my Patient Health information to the following person(s) or entities(s):

_____

Patient Health information authorized to be disclosed:

_____

For the specific purpose of (describe in detail):

_____

Effective dates for this authorization: ____/ ____/ ____ through ____/ ____/ ____ **or** □ until further notice is given.
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not Affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patients Authorized Representative *Date*

_____ _____
Signature of Ascent Sleep & Weight Representative *Date*