ABIDEEN O. YEKINNI, M.D.

PATIENT REGISTRATION

(Complete All Information)

PATIENT INFORMATION ***Date Completed***

Patient's Last Name:	Social Security No.:
First Name and Middle Initial:	Occupation:
Address:	Employer:
City: State: Zip Code:	Work Phone:
Home Phone:	Date of Birth: Age: Sex: M F
Cell Phone:	E-Mail Address:
Family Doctor:	
Address: City/State/Zip Code: Phone Number:	Ethnicity: (Circle the appropriate one) Alaska Native, American Indian, Asian, African American/Black, Hispanic, Latino, Native Hawaiian, Other Pacific Islander, White/Caucasian, Other

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (For minors, complete for parent or legal guardian)

Name:	Alternate Phone:
Address:	Social Security No.:
City: State: Zip Code:	Employer:
Home Phone:	Relationship to Patient:

NEAREST RELATIVE NOT LIVING WITH PATIENT:

Name:	Phone No.: Relationship:
Address:	City/State/Zip Code:

PRIMARY INSURANCE:	***SECONDARY INSURANCE:***
Insurance Co. Name:	Insurance Co. Name:
Policy No.	Policy No.
Group No.	Group No.

AUTHORIZATION AND ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid or any other insurance company with my/my dependent's care is covered any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance Company benefits be made on my behalf directly to Abideen O. Yekinni, M.D. for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, non-covered services, and services obtained without prior authorization from my insurance when required. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees. I authorize my physician to provide and perform medical/surgical care, tests, procedures, drugs and other services considered necessary or beneficial for my health and well being. I acknowledge that no guarantees have been made to me as to the results or cures due to treatments performed by my physician. A fee of $25 will be accessed and charged to me if I fail to keep a scheduled appointment without a 24 hour notice or cancellation or reschedule.

Patient/Legal Representative

Signature:____Date:____________________

Abideen O. Yekinni, M.D.
Patient Medical Information

(Complete all information)

PATIENT'S NAME_____________________________________
DATE:__________________________

CURRENT MEDICAL HISTORY/CONDITIONS
(CHECK EACH ONE THAT APPLIES)

☐ AIDS	☐ Dementia/Alzheimer	☐ Insulin Pump	☐ Shortness of Breath
☐ Alcoholism	☐ Depression	☐ Kidney disease	☐ Sinus Congestion
☐ Acid Reflux	☐ Diabetes	☐ Liver disease	☐ Sinus Infections Chronic
☐ Anemia	☐ Difficulty Swallowing	☐ Metal in Body	☐ Sleep Apnea
☐ Anxiety	☐ Ear Infections	☐ MRSA	☐ Stroke
☐ Arthritis	☐ Ear Pressure	☐ Migraines	☐ Thyroid Disorder
☐ Asthma	☐ Gout	☐ Noise in ears	☐ Tonsillitis
☐ A trial Fib/Flutter	☐ Headaches	☐ Nose Bleeds	☐ Tuberculosis
☐ Autism	☐ Heart Arrhythmia	☐ Osteoporosis	☐ Weight Loss
☐ Bleeding Disorders	☐ Heart Failure	☐ Pace Maker	☐ Weight Gain
☐ Balance/Dizziness	☐ Hearing Loss	☐ Pneumonia	☐ Wheezing
☐ Cancer (Type__________)	☐ Hepatitis (A B C)	☐ Popping/Cracking in Ear	
☐ COPD	☐ High/Low Cholesterol	☐ Psychiatric Disorder	
☐ Coronary Artery Disease	☐ Hypertension	☐ Pulmonary Embolism	
☐ Cough	☐ Insomnia	☐ Rheumatic Fever	
	☐ Irregular Heart Beat	☐ Seizure Disorder	

Any Hospitalizations/Surgeries	Year	DRUG ALLERGIES (IF YES, LIST)
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	
______________________________	________	

MEDICATIONS
(List all medications)

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

SOCIAL HISTORY

Caffeine Use	Yes	No	Number of drinks per day______
Alcohol Use	Yes	No	Number of drinks per week_____
Tobacco Use	Yes	No	Number of years_____ Number of packs per day______
Illicit Drug use	Yes	No	
Exercise	Yes	No	Number of times per week______
Special Diet	Yes	No	Type_______________
Marital Status	__________		
Height	__________		
Weight	__________		

WATERMARK MEDICAL ARES QUESTIONNAIRE

PATIENT DEMOGRAPHICS			SCORING
Last	**First**	**Middle Initial**	Neck Size **+2 ≥16.5 (Male)** **+2 ≥15.0 (Female)** ☐
Date of Birth	◯ **Male** ◯ **Female**	**ID#** **Optional**	
Height _____**feet** _____**inches**	**Weight** _____**pounds**	**Neck Size** _____**inches**	

MEDICAL CONDITIONS: **Have you been diagnosed or treated for any of the following conditions?**				
High Blood Pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	**+1 for each Yes response** ☐
Heart Disease	◯ Yes ◯ No	Depression	◯ Yes ◯ No	
Diabetes	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No	
Lung Disease	◯ Yes ◯ No	Nasal oxygen use	◯ Yes ◯ No	Do not assign any points for these eight responses
Insomnia	◯ Yes ◯ No	Restless legs syndrome	◯ Yes ◯ No	
Narcolepsy	◯ Yes ◯ No	Morning headaches	◯ Yes ◯ No	
Sleep Medication	◯ Yes ◯ No	Pain Medication	◯ Yes ◯ No	

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 work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

Situation					Scoring
Sitting and reading	0	1	2	3	Epworth Score **TOTAL** the values from all 8 questions. If 11 or less **Score = 0** If 12 or more **Score = 2** ☐
Watching TV	0	1	2	3	
Sitting, inactive, in a public place (theater, meeting, etc.)	0	1	2	3	
As a passenger in a car for an hour without break	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	

HABITS	**Never**	**Rarely 0-1 times/wk**	**Sometimes 1-2 times/wk**	**Frequently 3-4 times/wk**	**Always 5-7 times/wk**	
On average in the past month, how often have you snored or been told that you snore?	◯ +0	◯ +1	◯ +2	◯ +3	◯ +4	Habits Score **TOTAL** the values for all answers from first 3 habits questions ☐
Do you wake up choking or gasping?	◯ +0	◯ +1	◯ +2	◯ +3	◯ +4	
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	◯ +0	◯ +1	◯ +2	◯ +3	◯ +4	
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	◯ +0	◯ +0	◯ +0	◯ +0	◯ +0	

I have personally completed this questionnaire. **By signing this agreement,** you acknowledge that you have read, understand, and agree to the terms and conditions of the Patient Authorization form on the reverse side of this form.

Patient Signature_______________________________ Date_____________________

Patient Phone Number___________________________

Total all 4 boxes above.

Scoring Chart

≤3 = No Risk
4 or 5 = Low Risk
6 to 10 = High Risk
≥11 = Very High Risk

☐

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PATIENT AUTHORIZATION FORM FOR WATERMARK MEDICAL THERAPY CLEARINGHOUSE

You have expressed an interest in sleep apnea therapy and related durable medical equipment (DME). Watermark Medical Therapy Clearinghouse can provide certain assistance to you and your physician by determining which DME suppliers who participate in Watermark Medical Therapy Clearinghouse are in network with your insurance carrier. Based on your insurance coverage, Watermark Medical Therapy Clearinghouse will determine which DME suppliers who participate in Watermark Medical Therapy Clearinghouse are in network. Watermark Medical Therapy Clearinghouse will contact your physician and/or you with a list of potential DME suppliers and your physician (on your behalf) or you will select which DME supplier will supply the DME that your physician ordered for you.

By signing this Authorization, you understand that the list of available DME suppliers is limited to those DME suppliers who have decided to participate in Watermark Medical Therapy Clearinghouse and not all DME suppliers who are in network with your insurance carriers may participate in Watermark Medical Therapy Clearinghouse and it is possible that none of the DME suppliers who participate in Watermark Medical Therapy Clearinghouse may be in network. Further, you understand that Watermark Medical Therapy Clearinghouse is open to all DME suppliers who wish to participate and pay the appropriate fees and Watermark Medical Therapy Clearinghouse does not screen, or impose any restrictions or limitations on, any DME supplier and Watermark Medical Therapy Clearinghouse is not responsible for any DME or any services or products provided to you by a DME supplier who participates in Watermark Medical Therapy Clearinghouse. Any prior authorization approvals or any other payor requirements that need to be satisfied prior to providing any DME to you will be handled by the DME supplier who you and/or your physician selects.

The DME suppliers who are affiliated with Watermark Medical Therapy Clearinghouse pays Watermark Medical Therapy Clearinghouse for the services that Watermark Medical Therapy Clearinghouse conducts. Neither you nor your physician is charged for this service.

In order to provide assistance, Watermark Medical Therapy Clearinghouse (or its designee) will need to use your patient health information (called "Protected Health Information" or "PHI"), and to share it with your health plan and the DME supplier(s) who are part of Watermark Medical Therapy Clearinghouse. This authorization will allow your physician, healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to Watermark Medical Therapy Clearinghouse (or its designee) so that the Watermark Medical Therapy Clearinghouse may provide this assistance to your physician and/or to you. This authorization also permits Watermark Medical Therapy Clearinghouse to contact you to discuss potential DME suppliers who can provide the DME ordered by your physician and permits a DME supplier who participates in Watermark Medical Therapy Clearinghouse to contact you regarding the DME that your physician ordered for you.

Authorization and Signature:

By signing this Authorization, I authorize my physician and health plans to disclose and use my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any order or prescription for DME, to Watermark Medical Therapy Clearinghouse and its representatives, agents, and contractors, and DME suppliers who participate in Watermark Medical Therapy Clearinghouse for the following purposes: (1) to establish my eligibility for insurance coverage; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the selection of DME suppliers who are in network with my insurance plan; (4) to contact me to discuss my personal health information and potential DME suppliers who can provide the DME ordered by my physician; and (5) to facilitate coverage and reimbursement of DME ordered for me. I understand that my personal health information disclosed under this Authorization may no longer be protected by federal privacy law and may be re disclosed by Watermark Medical Therapy Clearinghouse. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits are not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Watermark Medical Therapy Clearinghouse, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed on the reverse side of this form.