

Midwest Sleep Specialists, LLC

Appointment Notification

Patient Information

Patient Name: _____ Patient ID: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ SSN: _____

Appointment Confirmation

Appt Date: _____ Provider: _____
Appt Time: _____ Location: _____

If you have not already done so, please fax us the following information prior to the patients appointment:

- Last H&P
- Office Notes
- TSH/Thyroid results
- Overnight Oximetries
- Previous Sleep Studies
- Anything else you feel would be helpful

Please fax the above information to 913-341-5958

Appointment Notification

- Your patient **cancelled** his/her appointment today in our office.
- Your patient **no-showed** his/her appointment today in our office.
- We've made 3 attempts to reach your patient by phone, with no response.

Thank you for your referral and please contact us if we can be of further assistance.

Sincerely,

Midwest Sleep Specialists, LLC

Steven G. Hull, MD
Scott E. Eveloff, MD
Eric D. Friskel, MD

Kansas

Overland Park
Lawrence
913-498-3003

Missouri

Lee's Summit
Northland
913-498-3003

Iowa

Waukee
Pleasant Hill
515-226-0179

Midwest Sleep Specialists, LLC

Epworth Sleepiness Scale

Patient Demographics

Patient Name: _____ Patient ID: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ SSN: _____

Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, on contract to feeling just 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 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

Situation

Chance of dozing

- | | |
|---|-------|
| 1. Sitting and reading | _____ |
| 2. Watching TV | _____ |
| 3. Sitting inactive in a public place (such as theater or in a meeting) | _____ |
| 4. As a passenger in a car for an hour without a break | _____ |
| 5. Lying down to rest in the afternoon when circumstances permit | _____ |
| 6. Sitting and talking to someone | _____ |
| 7. Sitting quietly after lunch | _____ |
| 8. In a car, while stopped for a few minutes in traffic | _____ |

I have reviewed the above information and acknowledge it's accuracy:

Signature: _____ Date: _____

Midwest Sleep Specialists, LLC

Patient Information Sheet

Patient ID: _____

Demographics

Last Name: _____	First Name: _____
Middle Init: _____	Preferred Name/Nickname: _____
Prefix: Mr/Mrs/Ms DOB: _____	Sex: M/F SSN: _____
Race: American/African-American/Hispanic-Latino/Asian/Hawaiian-Pacific Islander/American Indian	
Marital Status: M/S/W/D Drivers License: _____	Language: _____
Preferred Pharmacy (Name, Address, Phone): _____	
Address: _____	Home Phone: _____
City: _____	Work Phone: _____
State: _____	Cell Phone: _____
Zip: _____	Primary #: _____
Email: * _____	* Please note we do not have secure email at this time
Employer: _____	Emergency Contact Name: _____
Occupation: _____	Relationship: _____
	Contact Number: _____

Insurance

Primary Insurance Carrier: _____	
Policyholder: _____	
Policy #: _____	
Group #: _____	
If policyholder is someone other than patient, please complete the following:	
Name, address, city/state/zip & phone (including area code)	Policyholder's DOB & SSN#
Secondary Insurance Carrier: _____	
Policyholder: _____	
Group #: _____	
Policy #: _____	
If policyholder is someone other than patient, please complete the following:	
Name, address, city/state/zip & phone (including area code)	Policyholder's DOB & SSN#

Miscellaneous

Primary Care Physician: _____
Referring/Ordering Physician: _____
How did you hear about MSS? _____

I have reviewed the above information and acknowledge it's accuracy:

Signature: _____ Date: _____