Patient Information Change Form

Patient Name: _____ **Patient DOB: _____ /_____ /_____**

Please update any information below that has changed since your last visit, or

☐ Check here if no changes to any of the information below

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Insurance

Carrier: _____ Group: _____

Plan ID: _____

Policy Holder Name (if not self):_____ Relationship: _____

Policy Holder Date of Birth: _____/ _____/_____

Medications

☐ Check here for no medication(s) taken

_____ _____ _____

Allergies

☐ Check here for no allergies

_____ _____ _____

Neuro Diagnostic Sleep Centers

Appointment Date

_____/_____/_____

Review of Symptoms

Please Check ALL That Apply

CARDIAC	Chest Pain		Murmur(s)		Palpitation(s)	
CONSTITUTIONAL	Fatigue		Fever		Sleep Disorders	
	Weight Gain		Weight Loss			
EARS,NOSE,THROAT	Difficulty Swallowing		Hearing Aids		Ringing In Ears	
	Ear Pain		Hearing Loss			
ENDOCRINE	Diabetes		Thyroid			
EYES	Blurred Vision		Double Vision		Eye Pain	
GASTROINTESTINAL	Abdominal Pain		Constipation		Heartburn/Reflux	
	Bowel Incontinence		Diarrhea		Vomiting	
HEMATOLOGIC	Anemia		Easy Bruising			
INFECTIOUS	AIDS / HIV		Scabies		Tuberculosis	
	Hepatitis		Sexually Transmitted Disease(s)			
MUSCULOSKELETAL	Joint Pain		Muscle Pain		Other	
NEUROLOGICAL	Difficulty with Speech		Fainting/Black Out		Numbness	
	Difficulty Using Hands		Headache(s)		Seizures	
	Difficulty Walking		Memory Loss		Tingling	
	Dizziness		Muscle Weakness		Tremors	
PSYCHIATRIC	Anxiety		Bi-Polar Disorder		Depression	
RESPIRATORY	Asthma		Chronic Cough		Shortness of Breathe	
UROLOGIC	Kidney Stones		Painful Urination			
	Prostate Disorder		Urinary Hesitation			

NeuroDiagnostic Sleep Centers

Sleep Consultation Consent

I have been referred to AMDx, LTD (dba, NeuroDiagnostic Laboratories) for a sleep consultation to determine if I am a candidate for sleep therapy. If it is determined that I am an eligible candidate for sleep therapy, related service(s) will be scheduled and rendered at a later date.

I understand that the provider will be asking me a series of questions regarding my current condition in order to complete an evaluation and recommend possible treatment options.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP CONSULTATION.

Patient Name (printed): _____

Patient Signature:_____ Date: ____/____/____

If applicable, please print the name of the patient's representative:_____

Relationship to Patient: _____

Representative Signature: _____