# CFPG Patient Information & Authorization of Treatment

| Office Use Only | | |
|---|---|---|
| Account | Date | ☐Hospital ☐Mills ☐East ☐North |

*Please Print*

## Patient Information

**Patient Name:** ______________________________________ **Birth Date:** ______________ **Today's Date:** ___________

**Phone: Home** _________________________ **Cell** _________________________ **Work** __________________________

**Email:** _________________________________________ **Social Security Number:** _______________________________

**Gender:** ☐ **Male** ☐ **Female** **Language:** ________________ **Race:** __________________ **Ethnicity:** _________________

**Address:** _____________________________________________________________________________ **Apt:** ________

**City:** ____________________________ **State:** __________ **Zip:** _____________ **Marital Status:** ☐ **S** ☐ **M** ☐ **W** ☐ **D**

**Spouse/Guardian:** ____________________ **Social:** ________________ **Relationship:** _________ **Phone:** ______________

**Emergency Contact:** ________________________ **Relationship:** _______________ **Phone:** _______________________

## Pharmacy Information

**Pharmacy Name:** ____________________________ **Phone:** _______________________ **Fax:** ______________________

**Address:** __________________________________ **City:** ____________________ **State:** ______ **Zip:** _____________

## Referring Physician Information

**Physician Name:** ____________________________ **Phone:** _______________________ **Fax:** ______________________

**Address:** __________________________________ **City:** ____________________ **State:** ______ **Zip:** _____________

## Primary Care Physician Information

**Physician Name:** ____________________________ **Phone:** _______________________ **Fax:** ______________________

**Address:** __________________________________ **City:** ____________________ **State:** ______ **Zip:** _____________

***If my insurance requires an authorization and it has NOT been obtained, I realize I may be responsible for services rendered. I understand that I am financially responsible for charges rendered and that filing my insurance is a courtesy performed by this office.***

## Primary Insurance Information

**Insurance Name:** ___________________________ **Phone:** _______________________ **Is the patient retired?:** ☐ **Y** ☐ **N**

**Address:** __________________________________ **City:** ____________________ **State:** ______ **Zip:** _____________

**Policy No.:** ________________________ **Group Name/No.:** _______________________ **Effective Date:** ______________

**Employer Name:** ____________________________________ **Policy Holder's Name:** _____________________________

**Policy Holder's: Social** ______________________ **Birth Date** _______________ **Relationship to Patient** _______________

## Secondary Insurance Information

**Insurance Name:** ___________________________ **Phone:** _______________________ **Is the patient retired?:** ☐ **Y** ☐ **N**

**Address:** __________________________________ **City:** ____________________ **State:** ______ **Zip:** _____________

**Policy No.:** ________________________ **Group Name/No.:** _______________________ **Effective Date:** ______________

**Employer Name:** ____________________________________ **Policy Holder's Name:** _____________________________

**Policy Holder's: Social** ______________________ **Birth Date** _______________ **Relationship to Patient** _______________

# CFPG Patient Information & Authorization of Treatment – Page 2

## For Medicare Patients

I request that payment of authorized Medicare benefits be made to **Central Florida Pulmonary Group, P.A.**, for any services furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents, any information needed to determine these benefits or these benefits payable for related services. I also request that payment for authorized Medigap benefits be made on my behalf to **Central Florida Pulmonary Group, P.A**. for services provided. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will allow Medicare payment information to cross over automatically. This authorization serves as a lifetime authorization unless revoked in writing by me. A copy of this authorization may be used in place of the original.

**Beneficiary Signature:** ________________________________________________________________ **Date:** __________________

**Authorized Representative Signature (if applicable):** ________________________________________ **Date:** __________________

## For Non Medicare Patients

I authorize release of any medical information necessary to process this claim and related claims. I request that payment of authorized benefits be made on my behalf to **Central Florida Pulmonary Group, P.A.** for any services furnished to me. This authorization serves as a lifetime authorization unless revoked in writing by me. A copy of this authorization may be used in place of the original.

**Beneficiary Signature:** ________________________________________________________________ **Date:** __________________

**Authorized Representative Signature (if applicable):** ________________________________________ **Date:** __________________

## All Patients

I agree to pay all balances owed, including, but not limited to, coinsurance, co-payments, deductible, and non-covered services promptly upon presentation thereof. Balances as shown by statements are agreed to be correct unless protested in writing within thirty days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claim thereon. If your bill remains unpaid, you will be held responsible for all collection costs including collection agency fees. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

**Beneficiary Signature:** ________________________________________________________________ **Date:** __________________

**Authorized Representative Signature (if applicable):** ________________________________________ **Date:** __________________

## Consent For Treatment

The patient and/or authorized representative of the patient whose signature is affixed below does hereby consent to medical treatment which may be deemed advisable by my physician/provider. The intention, hereof, being to grant authority to administer and perform all examinations, treatment, and diagnostic procedures which may now or during the course of my care be deemed necessary.

**Beneficiary Signature:** ________________________________________________________________ **Date:** __________________

**Authorized Representative Signature (if applicable):** ________________________________________ **Date:** __________________

## Patient Permission To Communicate Medical Information

The patient and/or authorized representative of the patient whose signature is affixed below does hereby permit and does not object to the communication of medical information related to my care and condition to the following two individuals (e.g. spouse, son, daughter, friend, etc.)

**Name of Individual:** __________________________________ **Relationship:** ________________ **Phone:** ______________________

**Name of Individual:** __________________________________ **Relationship:** ________________ **Phone:** ______________________

**Beneficiary Signature:** ________________________________________________________________ **Date:** __________________

**Authorized Representative Signature (if applicable):** ________________________________________ **Date:** __________________

# CFPG Patient Authorization For Use & Disclosure of Protected Health Information

*Please Print*

## Patient Information

**Patient Name:** ________________________________________ **Birth Date:** ________________ **Social:** ______________________

## Authorization

By signing this authorization, I authorize *Central Florida Pulmonary Group, P.A.* to ***obtain/release*** certain protected health information (PHI) about me from or to:

______________________________________________________________________________________________________________

***(Name and address of entity being asked to release or to obtain information from)***

The information requested to be obtained from the entity listed above should be sent to:

***Attention: Medical Records, Central Florida Pulmonary Group***

☐ *326 North Mills Avenue, Orlando, Florida 32803*
☐ 10916 Dylan Loren Circle, Orlando, Florida 32825
☐ 610 Jasmine Road, Altamonte Springs, Florida 32701

This authorization permits the following individually identifiable health information about me to be **obtained/released** for the specified date or period:

Records obtained/released are for the date(s) of _________________________________ or the period from _____________ to _____________

☐ My complete medical record ☐ Other ____________________________________________________________________________

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on ___________________________(date supplied by patient); (3) under the following condition(s): ________________________________

______________________________________________________________________________________________________________

When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the federal Privacy Rule.

**My written revocation must be submitted to the Privacy Officer at:**

***Central Florida Pulmonary Group, P.A.***
***326 North Mills Avenue***
***Orlando, Florida 32803***

I understand and agree that I am financially responsible for appropriate fees associated with my request in accordance with Florida Administrative Code, Rule 64B-10.003 which states that "(1) Any person licensed pursuant to Chapter 458, Florida Statutes, required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records. (2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: (a) For the first 25 pages, the cost shall be $1.00 per page. (b) For each page in excess of 25 pages, the cost shall be 25 cents. (3) Reasonable costs of reproducing X-rays, and other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication."

The cost of postage related to mailing is a separate fee that may be charged and is unrelated to the costs of reproduction.

Signature of Patient : ___________________________________ Print Name: ______________________ Date: ______________________

Signed by Personal Representative/Guardian*:* ____________________ Print Name: ___________________ Date: ______________________

Description of personal representative/guardian authority to act on behalf of the patient: _______________________________________________

Witness Signature: ____________________________________ Print Name: _______________________ Date: ______________________

## For Internal Purposes Only

Completed by: ______________________________ Date completed: ________________ ❒Fax ❒Pick-up ❒Mailed ❒Other: ___________

# CFPG Financial Policy

*Please Print*

## Patient Information

**Patient Name:** ________________________________________ **Birth Date:** ________________ **Social:** ______________________

## Consent For Treatment

Welcome to our medical practice. We are committed to providing you with the best possible care and services. If you have insurance, we are anxious to help you to receive your maximum plan benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

**Balances owed for services rendered are due at the time of service and are rendered unless payment arrangements have been preapproved by our billing department. Copays will be collected the day of your appointment. We accept cash, checks, Visa, Mastercard and debit cards. We will file a claim for your primary insurance. Patient balances greater than 30-days old may be charged a monthly late fee of $5.00 with each patient statement.**

Please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that specific contract.
2. We have established our charges based on the actual value of the services. We do, however, provided significant adjustments to those services with many insurance companies.
3. Not all services rendered are a covered benefit with all insurance company contracts that you or your employer may have chosen. It is important for you to have an understanding of the benefits and regulations associated with your health plan.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. Follow up on outstanding claims with your insurance company may require your intervention; and we appreciate your working with us in that regard. We realize that temporary financial problems may affect timely payment of your account. However, if such a problem should occur, we expect you to contact us promptly for assistance. If you have questions about the information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. WE ARE HERE TO TRY TO HELP YOU.

**Policies Related To Medicare and Medicare Supplement Insurance**
We are a participating provider with the Medicare Part B program; and as such are obligated to write off the difference between Medicare's allowed amount and our charge. Medicare pays 80% of that allowed amount to us directly. The 20% copay and annual deductible is the patient responsibility by federal law.

We do not manually file claims to your Medicare supplement. If Medicare transmits your supplemental information for payment to your insurance company, we will allow 30 days for payment. After 30 days, payment to our office and collection from your supplemental insurer will be your responsibility.

**Policies of Contracted Managed Care Companies**
In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all the individual requirements of the many various plans. Each one has different stipulations regarding what services may be rendered and, even more importantly, where and who those services may be performed by. Even within the same insurance company, the plans differ depending upon what types of contracts you or your employer requested.

Providing quality medical care for our patients is our primary concern. We will provide that care within your contract guidelines, but we expect you to contact your plan and to actively participate in knowing your plan regulations as services are rendered. **If a treatment authorization is required by your plan, please be sure that our office is in receipt of that authorization PRIOR to your appointment or your appointment may require rescheduling.**

If you do not inform us of any special requirements in your contract, and we subsequently order services such as lab work, medical equipment, outpatient diagnostic services, hospitalization, or any other services recommended by your physician that are not covered, we or the selected medical facility will have no alternative but to bill you directly for those charges. Payment for those charges is your responsibility.

With your cooperation and direction you should be able to receive all the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

**Beneficiary Signature:** ______________________________________________________________ **Date:** __________________

**Authorized Representative Signature (if applicable):** ________________________________________ **Date:** __________________

# CFPG Patient Medical History Form

| Office Use Only | | |
|---|---|---|
| Account | Date | ☐Hospital ☐Mills ☐East ☐North |

*Please Print*

## Patient Information

**Patient Name:** ______________________________________________ **Age:** _______________ **Today's Date:** ____________

**Current Occupation:** ____________________________ **If retired, previous occupation:** _______________________________

## Today's Visit

**What is the main reason for today's visit, and when did you first notice this problem?**

## Current Problems

**Please check any current problems you are having. If yes, please explain.**

- ☐ Shortness of breath ☐ Yes ☐ No ____________________
- ☐ Wheezing ☐ Yes ☐ No ____________________
- ☐ Hay fever (allergies) ☐ Yes ☐ No ____________________
- ☐ Cough ☐ with phlegm ☐ with blood ☐ Yes ☐ No Color: ____________________
- ☐ Fevers ☐ Yes ☐ No ____________________
- ☐ Recent weight change ☐ Yes ☐ No ____________________
- ☐ Sleeping disorder ☐ Yes ☐ No ____________________
- ☐ Difficulty swallowing ☐ Yes ☐ No ____________________
- ☐ Chest pain ☐ Yes ☐ No ____________________

## Medications

**Prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.**

| Medication | Dose (e.g., mg/pill) | How many times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergies or reactions to medications:** ________________________________________________

## Allergies

**Please check any current allergies you have.**

| | | | | |
|---|---|---|---|---|
| ☐ Ace Inhibitors | ☐ Anesthesia | ☐ Antihistamines | ☐ Aspirin | ☐ Codeine |
| ☐ Dairy Products | ☐ Iodine | ☐ Latex | ☐ Mold | ☐ Penicillin |
| ☐ Pet Dander | ☐ Prednisone | ☐ Sulfa Drugs | ☐ X-ray Dye | ☐ No Known Allergies |

**Other Allergies:** ______________________________________________________________

## Immunizations

**Date of your most recent IMMUNIZATION: Influenza (flu shot)** _________ **Pneumovax (pneumonia)** _________ **Other:** ______________

# CFPG Patient Medical History Form – Page 2

## Patient Information

**Patient Name:** ____________________________________________ **Birth Date:** ______________ **Today's Date:** _____________

## Testing

**Please check any recent testing you had.**

| Type of Test | When | Where | Results (If Known) |
|---|---|---|---|
| TB Skin Test | | | |
| Chest X-ray/CT Scan | | | |
| Pulmonary Function Test (PFT) | | | |

## Past Surgical/Hospitalization History

**Please list all prior operations/hospitalization (with dates).**

| Type of Surgery/Hospitalization | Where (e.g. name of hospital or facility) | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Past Medical History

**Please check if you have ever been diagnosed with any of the following.**

| | | | | |
|---|---|---|---|---|
| ☐ Allergies | ☐ Alzheimer's | ☐ Anemia | ☐ Aneurysm | ☐ Anxiety |
| ☐ Arrhythmias | ☐ Arthritis | ☐ Aspirations | ☐ Asthma | ☐ Bronchiectasis |
| ☐ Bronchitis | ☐ Cancer | ☐ Cardiac Arrest | ☐ Cardiac Arrhythmias | ☐ Cardiac Disease |
| ☐ Colitis | ☐ Congestive Heart Failure | ☐ COPD | ☐ Coronary Artery Disease | ☐ Chronic Cough |
| ☐ Cystic Fibrosis | ☐ Diabetes | ☐ Emphysema | ☐ Fissure | ☐ GERD/Heart Burn |
| ☐ Heart Disease | ☐ Hepatitis | ☐ Hernia | ☐ HIV/AIDS | ☐ Hodgkin's Disease |
| ☐ Hyperactive Airway | ☐ Hypertension | ☐ Hyperthyroidism | ☐ Hypothyroidism | ☐ Incontinence |
| ☐ Irregular Heart Beat | ☐ Kidney Stones | ☐ Leukemia | ☐ Lung Cancer | ☐ Melanoma |
| ☐ Migraines | ☐ Neuropathy | ☐ Non-Hodgkin's Lymphoma | ☐ Obesity | ☐ Parkinson's Disease |
| ☐ Pleural Effusion | ☐ Pleurisy | ☐ Pneumonia | ☐ Pneumothorax | ☐ Pulmonary Emboli |
| ☐ Pulmonary Fibrosis | ☐ Pulmonary Hypertension | ☐ Raynaud's Phenomenon | ☐ Renal Failure | ☐ Rheumatic Fever |
| ☐ Sarcoidosis | ☐ Scleroderma | ☐ Scoliosis | ☐ Seizures | ☐ Sinus Condition |
| ☐ Sleep Disturbance | ☐ Stridor | ☐ Stroke, TIA, CVA | ☐ Stomach Ulcers | ☐ Thyroid Disorder |
| ☐ Tuberculosis (TB) | ☐ Other: ______________________________ | | | |

## Exposures

**Have you ever been exposed to any of the following?**

| | | | |
|---|---|---|---|
| ☐ asbestos | ☐ carpenter's wood dust | ☐ dust | ☐ radiation |
| ☐ ammonia | ☐ chemical/toxin | ☐ feathers | ☐ silica |
| ☐ agent orange | ☐ chemical fumes or gases | ☐ fiberglass | ☐ soldering/welding |
| ☐ animals/pets | ☐ chlorine | ☐ mold growing in house | ☐ tobacco exposure |
| ☐ burns wood in home | ☐ coal dust | ☐ oil or kerosene burning heater in home | ☐ UV overexposure |

# CFPG Patient Medical History Form – Page 3

## Patient Information

**Patient Name:** ______________________________________________ **Birth Date:** ______________ **Today's Date:** _____________

## Family History

**Please indicate the current status of your immediate family members. Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.**

| Condition | | Condition | |
|---|---|---|---|
| Addison's disease | ____________________ | High cholesterol | ____________________ |
| Alcoholism | ____________________ | Hypertension | ____________________ |
| Alzheimer's disease | ____________________ | Kidney disease | ____________________ |
| Asthma | ____________________ | Lupus | ____________________ |
| Autoimmune disorder | ____________________ | Obesity | ____________________ |
| Cancer (list type) | ____________________ | Osteoporosis | ____________________ |
| Cardiovascular | ____________________ | Respiratory disease | ____________________ |
| COPD | ____________________ | Rheumatoid arthritis | ____________________ |
| Cystic fibrosis | ____________________ | Schizophrenia | ____________________ |
| Diabetes | ____________________ | Sickle cell disease | ____________________ |
| Emphysema | ____________________ | Stroke | ____________________ |
| Fibromyalgia | ____________________ | Thyroid disease | ____________________ |
| Heart problems | ____________________ | Tuberculosis | ____________________ |
| Hepatitis | ____________________ | Other: | ____________________ |

## Tobacco Use

**Cigarettes**:

- ☐ Never Smoked
- ☐ Former Smoker: ☐ Quit Date ________________________. Packs per day _________ for _________ number of years
- ☐ Current Every Day Smoker. Packs per day _________ for _________ number of years
- ☐ Current Some Day Smoker. Packs per day _________ for _________ number of years
- ☐ Current Status Unknown

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

**Are you interested in quitting? ☐ Yes ☐ No**

## Alcohol Use

Do you drink alcohol? ☐ Yes, number of drinks/week _______________ ☐ No

## Drug Use

Do you use recreational drugs? ☐ Yes ☐ No

## Caffeine Use

Do you drink/use caffeine (Coffee/tea/soda)? ☐ Yes, number of cups/day _________ ☐ None

# CFPG Sleep Questionnaire

| Office Use Only | | |
|---|---|---|
| Account | Date | ❑Hospital ❑Mills<br>❑East ❑North |

*Please Print*

## Patient Information

**Patient Name:** ___________________________________________________________ **Today's Date:** ___________________

**Sex: ❑Male ❑Female Weight:** ______________**lbs. Height:** ___________**foot** ____________**inches Age:** ____________

## Part 1

**Instructions:** Please circle that one number following each statement that best describes how often you have had any of these experiences. Unless otherwise noted, the statements refer to what has been happening to you during the past six (6) months. Circling number "1" after a statement means that you have never had that experience, whereas circling number "5" means that you almost always have that experience.

**Answer Key: 1 = Never 2 = Rarely 3 = Sometimes 4 = Usually 5 = Always**

1. I have difficulty falling asleep ________ 1 2 3 4 5
2. When I awaken during the night I am unable to fall back to sleep ________ 1 2 3 4 5
3. At bedtime I am afraid of not being able to fall asleep ________ 1 2 3 4 5
4. I sleep better when sleeping away from my home ________ 1 2 3 4 5
5. Thoughts race through my mind when I am trying to go to sleep ________ 1 2 3 4 5
6. I use alcohol to help me get to sleep ________ 1 2 3 4 5
7. I use medications to help me get to sleep ________ 1 2 3 4 5
8. My sleep is disturbed because of pain ________ 1 2 3 4 5
9. I am anxious or depressed ________ 1 2 3 4 5
10. I have been told that I snore ________ 1 2 3 4 5
11. I have been told that my snoring can be heard in other rooms of the house ________ 1 2 3 4 5
12. I suddenly wake up gasping or choking ________ 1 2 3 4 5
13. I have been told I stop breathing at times during my sleep ________ 1 2 3 4 5
14. I have headaches when I wake up in the morning ________ 1 2 3 4 5
15. At times during the day I struggle to stay awake ________ 1 2 3 4 5
16. I have trouble at work or school because of sleepiness ________ 1 2 3 4 5
17. I have fallen asleep during the day involuntarily ________ 1 2 3 4 5
18. At times during the day I am so tried that I find myself doing things that make no sense ________ 1 2 3 4 5
19. I have been told that I kick my legs when I sleep ________ 1 2 3 4 5
20. My sleep is disturbed by aching or crawling sensations in my legs ________ 1 2 3 4 5
21. I get out of bed to walk and stretch my legs because of discomfort ________ 1 2 3 4 5
22. When awakening or falling asleep, I have been awake but felt paralyzed or unable to move ________ 1 2 3 4 5
23. When awakening or falling asleep, I have experienced vivid dreamlike visions or heard voices ________ 1 2 3 4 5
24. I have sudden attacks of muscular weakness when laughing, crying or otherwise very emotional ________ 1 2 3 4 5
25. I sleep walk at times ________ 1 2 3 4 5
26. I wake up screaming, confused or violent at times ________ 1 2 3 4 5

# CFPG Sleep Questionnaire

*Please Print*

| Patient Information | |
|---|---|
| **Patient Name:** ______________________________________________ | **Today's Date:** ___________________ |

## Part 2 – The Epworth Sleepiness Scale

How likely are you to dose off or fall asleep in the following situations, in contrast 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:

| Answer Key: 0 = Would never doze 1 = slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing |
|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Sitting and reading | ______ | 0 | 1 | 2 | 3 |
| 2. | Watching T.V. | ______ | 0 | 1 | 2 | 3 |
| 3. | Sitting inactive in a public place (i.e. a theatre, a meeting | ______ | 0 | 1 | 2 | 3 |
| 4. | As a passenger in a car for an hour without a break | ______ | 0 | 1 | 2 | 3 |
| 5. | Lying down to rest in the afternoon when circumstances permit | ______ | 0 | 1 | 2 | 3 |
| 6. | Sitting and talking to someone | ______ | 0 | 1 | 2 | 3 |
| 7. | Sitting quietly after a lunch without alcohol | ______ | 0 | 1 | 2 | 3 |
| 8. | In a car, while stopped for a few minutes in traffic | ______ | 0 | 1 | 2 | 3 |

## Part 2

| | |
|---|---|
| 1. | Do you work shifts or irregular hours? If so, please explain: |
| 2. | Is there a history for sleep problems in your family? If so, please explain: |
| 3. | Do you seem to sleep best at times different from most people you know? If so, please explain: |
| 4. | Did you have sleeping problems during childhood (i.e. sleep walking, night terrors, etc)? If so, please explain: |
| 5. | Do you drink caffeinated beverages (i.e. coffee, tea, colas)? If so, how many drinks per day? |
| 6. | Have you had any history for emotional or other psychiatric problems? If so, please explain: |
| 7. | Are there any other issues that you would like to bring to the doctors attention? If so, please explain: |

# Directions to Downtown Orlando Office


## Central Florida Pulmonary Group, P.A.

326 North Mills Avenue
Orlando, Florida 32803

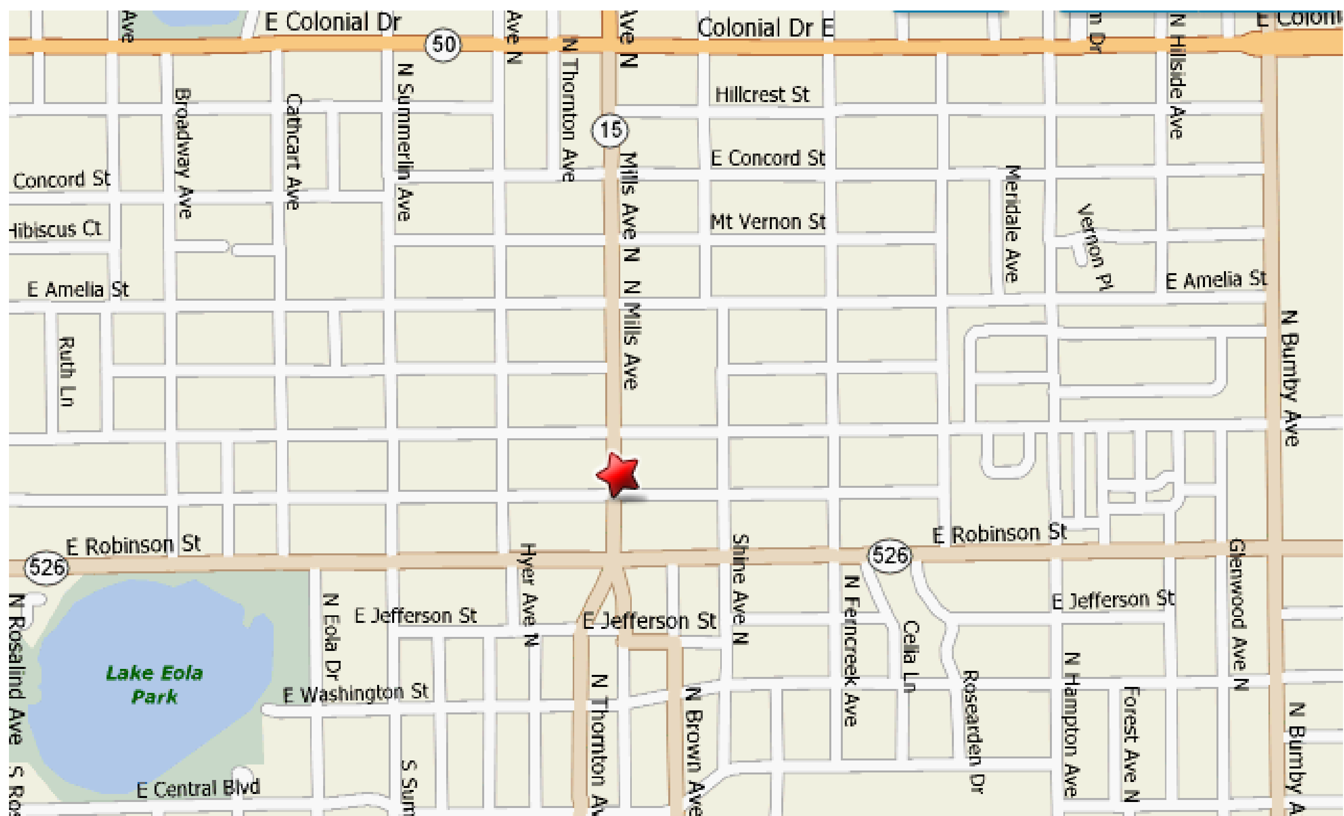
Phone: 407-841-1100
Fax: 407-843-7983

**Coming from West I-4:**

- Exit Colonial Drive (SR 50)
- Turn LEFT onto East Colonial Drive
- Make RIGHT onto Mills Avenue (17-92)
- Make a RIGHT onto Ridgewood Street
- End at 326 North Mills Avenue on RIGHT

**Coming from East I-4:**

- Exit Colonial Drive (SR 50)
- Turn RIGHT onto East Colonial Drive
- Make RIGHT onto Mills Avenue (17-92)
- Make a RIGHT onto Ridgewood Street
- End at 326 North Mills Avenue on RIGHT



# Directions to East Orlando Office

## Central Florida Pulmonary Group, P.A.

10916 Dylan Loren Circle
Orlando, Florida 32825

Phone: 407-841-1100
Fax: 407-843-7983

**From the 408E**

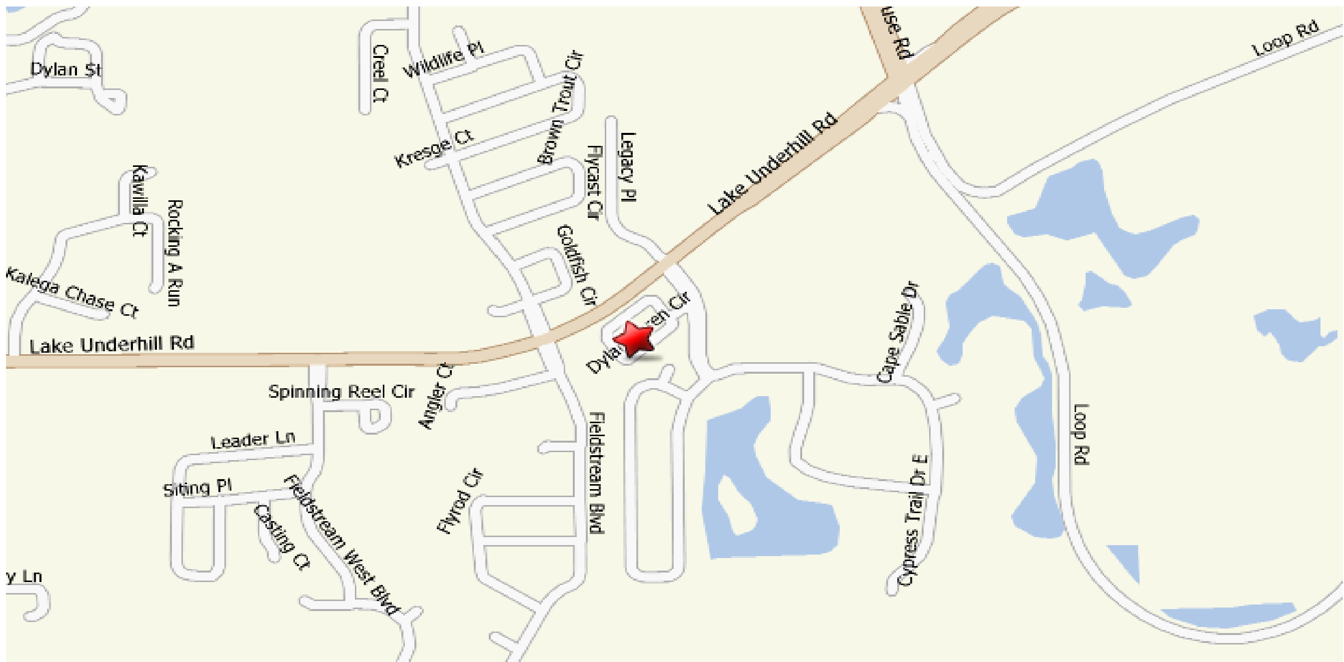
- Exit 20 (Rouse Road)
- Turn RIGHT onto Rouse Road
- Turn RIGHT onto Lake Underhill
- Turn LEFT at Cypress Hammock
- Take first RIGHT onto Dylan Loren Circle
- End at 10916 Dylan Loren Circle

**From West headed East on Lake Underhill**

- Cross Dean Road
- Turn RIGHT at Legacy Drive
- Take first RIGHT onto Dylan Loren Circle
- End at 10916 Dylan Loren Circle

**From East headed West on Lake Underhill**

- Turn LEFT at Cypress Hammock
- Take first RIGHT onto Dylan Loren Circle
- End at 10916 Dylan Loren Circle



# Directions to Altamonte Springs Office

## Central Florida Pulmonary Group, P.A.


610 Jasmine Road
Altamonte Springs, Florida 32701

Phone: 407-841-1100
Fax: 407-843-7983

**Coming from West I-4:**

- Exit Altamonte Springs/Apopka (SR 436)
- Turn LEFT onto East Altamonte Drive (SR 436)
- Turn RIGHT onto Boston Avenue
- Turn LEFT onto Jasmine Road
- End at 610 Jasmine Road on RIGHT

**Coming from East I-4:**

- Exit Altamonte Springs/Apopka (SR 436)
- Turn RIGHT onto East Altamonte Drive (SR 436)
- Turn RIGHT onto Boston Avenue
- Turn LEFT onto Jasmine Road
- End at 610 Jasmine Road on RIGHT