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Chase Dental SleepCare of Weston

SLEEP SCREENING QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION TODAY'S DATE:

MR MRS DR
MS MISS NAME: _____

AGE: _____ BIRTH DATE: _____ MALE FEMALE

ADDRESS: _____

CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS: _____ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____

ADDRESS: _____

SS #: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

FAMILY DENTIST: _____

ADDRESS: _____

PLEASE LIST OTHER HEALTH CARE PRACTICIONERS SEEN IN THE LAST 9 MONTHS: _____

_____

INSURANCE _____

MENMBER NUMBER: _____

GROUP NUMBER: _____

PLAN NUMBER: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

HEIGHT _____ feet _____ inches

WEIGHT _____ pounds

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

__ Frequent heavy snoring
__ Which affects the sleep of others
__ Significant daytime drowsiness
__ I have been told that "I stop breathing" when sleeping
__ Difficulty falling asleep
__ Nighttime choking spells
__ Feeling unrefreshed in the morning
__ Morning hoarseness
__ Morning headaches
__ Swelling in ankles or feet
__ Nocturnal teeth grinding
__ Jaw pain
__ Facial pain
__ Jaw clicking Other: _____

PATIENT SIGNATURE: _____ DATE: _____

List any medications which have caused an allergic reaction

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:

_____
_____
_____
_____
_____

List any medications you are currently taking

Y☐ N☐ Antacids
Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Antidepressants
Y☐ N☐ Anti-inflammatory drugs (non-steroid)
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet Pills
Y☐ N☐ Heart Medication
Y☐ N☐ High Blood Pressure Medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle Relaxants
Y☐ N☐ Nerve Pills
Y☐ N☐ Pain Medication
Y☐ N☐ Sleeping Pills
Y☐ N☐ Sulfa Drugs
Y☐ N☐ Tranquilizers

Other current medications:

_____
_____

Medical History

Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune Disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Chronic sinus problems
Y☐ N☐ Chronic fatigue
Y☐ N☐ Congestive heart failure
Y☐ N☐ Current pregnancy
Y☐ N☐ Diabetes
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent sore throats
Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
Y☐ N☐ Hay fever
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pounding or beating irregularly during the night
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to:
☐ Face ☐ Neck ☐ Head ☐ Neck ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nighttime sweating
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor Circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Thyroid problems
Y☐ N☐ Tonsillectomy
Y☐ N☐ Wisdom teeth extraction

Other medical history:

_____
_____
_____
_____

Patient Signature: _____ Date: _____

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? ☐ YES ☐ NO

If "YES":

Sleep Center Name: _____

Location: _____

Sleep Study Date: _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ☐ mild ☐ moderate ☐ severe obstructive sleep apnea

The evaluation showed an RDI of _____ and as AHI _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Family History

1. Have any members of your family (blood kin) had ☐YES ☐NO Heart disease
☐YES ☐NO High blood pressure
☐YES ☐NO Diabetes

2. Have any immediate family members been diagnosed or treated for a sleep disorder? ☐YES ☐NO

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?
☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?
☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Caffeine consumption: How often do you consume caffeine 2-3 hours before bedtime?
☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Do you smoke? ☐YES ☐NO
If yes, enter the number of packs per day (or other description of quantity)_____

Do you use chewing tobacco? ☐YES ☐NO

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all treatment regardless of insurance coverage.

Patient Signature _____ Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____ weight _____ male/female _____

2. Do you snore?
- ☐ Yes
- ☐ No
- ☐ Don't know

If you snore:

3. Your snoring is?
- ☐ Slightly louder than breathing
- ☐ As loud as talking
- ☐ Louder than talking
- ☐ Very loud, Can be heard in adjacent rooms

4. How often do you snore?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

5. Has your snoring ever bothered other people?
- ☐ Yes
- ☐ No

6. Has anyone noticed that you quit breathing during your sleep?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

7. How often do you feel tired or fatigued after you sleep?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?
- ☐ Neatly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?
- ☐ Yes
- ☐ No

If Yes, how often does it occur?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

10. Do you have high blood pressure?
- ☐ Yes
- ☐ No
- ☐ Don't know

(For office use)

Scoring Questions - Any answer within the box is a positive response

Scoring Categories

Category 1 is positive with 2 or more positive responses to questions 2-6 ☐

Category 2 is positive with 2 or more positive responses to questions 7-9 ☐

Category 3 is positive with 1 positive response and/or a BMI>30 ☐

BMI = Body Mass Index

Final Result 2 or more possible categories indicates a high likelihood of Sleep disordered breathing

Patient Signature _____ Date_____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
As a passenger in a car For an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total Score:_____
(add columns 0-3)

Patient Signature: _____ Date: _____

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Patient Release of Medical Records Form

(Please Print or Type)

_____ (_____) request and give permission to release my
Patient's Name Date of Birth

Polysomnography and Titration Reports to:

CHASE DENTAL SLEEPCARE OF WESTON
2239 N. Commerce Pkwy, Suite 1
Weston, Florida 33326
Ph: 954-349-4004
Fx: (866) 222-9193

_____ _____ _____-_____-_____
Patient's Name (print) Date of Birth Social Security #

_____ _____
Patient's Signature Today's Date

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CPAP NON COMPLIANT FORM

Patient Name: _____
Date: _____/_____/_____

It has been recommended and/or I have attempted to use CPAP (Continuous Positive Airway Pressure) to manage my diagnosed Obstructive Sleep Apnea condition. I find CPAP intolerable to use on a regular basis due to the following reason(s):

____ The mask leaks
____ I am unable to sleep with the CPAP mask and equipment in place
____ I unconsciously remove the CPAP at night
____ The noise from the device disturbs my sleep
____CPAP does not seem to be effective in reducing/eliminating my symptoms
____ I have tried multiple masks and none are comfortable enough to use
____ I develop sinus/ear/throat/ infections
____ I am claustrophobic
____ My job/ lifestyle prevent nightly use (Army, Reserves, Truck Driver)
____ Other:_____

Because of my intolerance and inability for CPAP to effectively treat my condition, I wish to attempt an alternative therapy. As per the 2006 practice parameters from the American Academy of Sleep Medicine I wish to utilize an oral airway dilator appliance to treat my obstructive sleep apnea.

Patient Signature _____
Date ____/____/_____

- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement

of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

---tear here---

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of [*name of dentist's*] Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

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Informed Consent for the Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?
Oral appliance therapy for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder.

A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy
Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders
Other accepted treatments for sleep-related breathing disorders include behavioral modification, Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below.
You will receive a copy.

Signature: _____ Date: _____

Print Name: _____

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Website: www.ChaseDentalSleepCare.com

Chase Dental SleepCare of Weston

Patient's Name: _____
Medicare or Private Insurance # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. If Medicare or your Private Insurance does not pay for item(s) or service(s) that are described below:

Custom Oral Appliance

Medicare or your Private Insurance may not pay for all or some of your health care costs. Your insurance only pays for covered items and services when their rules are met. The fact that they may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance may not pay for Items or Services listed below:

Custom Oral Appliance

Because:

- Secondary Deductible may have not been met
- AHI too Low
- Need to try CPAP first
- Open Workman's Comp case or No-Fault case
- Do not have benefits for this procedure

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance company probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX WITH YOUR INITIALS. SIGN & DATE YOUR CHOICE.

Option 1

_____YES: I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

Option 2

_____NO: I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company won't pay.

_____
Date

_____
Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare or your Private Insurance, your health information on this form may be shared with Medicare or your private insurance, your health information which Medicare sees will be kept confidential by Medicare or your Private Insurance.