

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER - -	BIRTHDATE / /	HOME PHONE ()
Home Address	City, State, Zip		WORK PHONE ()
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated Occupation / Employer / Bus Add.	Drivers License and State _____ Email Address _____		CELL PHONE ()
Primary Insurance Company _____ Group _____ Subscriber _____			
Secondary Insurance Company _____ Group _____ Subscriber _____			

Responsible Party		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ()
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address	City	State Zip

How did you hear about our Office?

Where did you find the Phone Number to this Office? _____

- Referred by a friend Yellow Pages Relative Insurance Plan Welcome Wagon
 Other _____ TV/Radio Ad Newspaper Ad Direct Mailing Sign by Building

If you were referred, whom may we thank for referring you? _____**CONSENT**

I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____

Date _____

Relationship to Patient _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. There is a \$25.00 service fee for returned checks. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or you rassignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____

Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Total Score:
				<u> </u>
				<i>(Add columns 0-3)</i>

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

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

- | | |
|--|---|
| <input type="checkbox"/> Frequent heavy snoring | <input type="checkbox"/> Morning hoarseness |
| <input type="checkbox"/> which affects the sleep of others | <input type="checkbox"/> Morning headaches |
| <input type="checkbox"/> Significant daytime drowsiness | <input type="checkbox"/> Swelling in ankles or feet |
| <input type="checkbox"/> I have been told that "I stop breathing" when sleeping. | <input type="checkbox"/> Nocturnal teeth grinding |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Gasping when waking up | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Nighttime choking spells | <input type="checkbox"/> Jaw clicking |
| <input type="checkbox"/> Feeling unrefreshed in the morning | |

Other: _____

Patient Signature _____

Date _____

INFORMED CONSENT

FOR THE TREATMENT OF SLEEP DISORDERED BREATHING WITH ORAL APPLIANCES

Snoring and obstructive sleep apnea are both breathing disorders that occur during sleep due to narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may often be no more problematic than the noise itself. However, consistent, loud, heavy snoring has been linked to medical disorders such as high blood pressure. Obstructive sleep apnea is a serious condition; the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, this can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure, reflux, depression, occasionally heart attack and stroke.

Because any sleep disordered breathing may potentially represent a health risk, all individuals will be tested by an overnight sleep recorder in their home or by a polysomnogram in a sleep laboratory.

Oral appliances may be helpful in the treatment of snoring, upper airway resistance syndrome (UARS), and sleep apnea. Oral appliances are designed to assist breathing by keeping the jaw and tongue forward, thereby opening the airway space in the throat. While documented evidence exists that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrow airway space in the throat and excess weight. Because each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or apnea for everyone. Post testing will be done to assure effective treatment.

POSSIBLE COMPLICATIONS

Some people may not be able to tolerate the appliance in their mouths. Also, some individuals will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and a slight change in their "bite". However, these usually diminish within an hour after appliance removal in the morning. On a rare occasion, a permanent "bite" change may occur due to jaw joint changes and/or tooth movement. Generally, this can be prevented with modifications to the appliance. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative, orthodontic, and/or surgical treatment may be required for which you are responsible. Oral appliances can wear and break. The rare possibility that these or broken parts from them may be swallowed or aspirated exists. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use is a hazard to your health and can lead to a heart attack, or stroke, and even death. See your prescriber before discontinuing use and for recommendations of alternative therapy such as CPAP and or surgery.

LENGTH OF TREATMENT

The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. Therefore, over time, the device must be worn nightly for a lifetime to be effective. Over time, simple snoring may develop into sleep apnea. Sleep apnea also may become worse. Therefore, the appliance may not maintain its effectiveness. The oral appliance needs to be checked at least twice a year to ensure proper fit and the mouth examined at that time to assure a healthy condition. If any unusual symptoms occur,

you are advised to schedule an office visit to evaluate the situation.

Individuals who have been diagnosed as having sleep apnea may notice that after sleeping with an oral appliance they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high to prevent abnormal heart rhythms and other problems is to be retested with a sleep recorder or polysomnogram.

ALTERNATIVE TREATMENTS

Other accepted treatments for sleep-disordered breathing include behavior modification, weight loss, constant positive airway pressure, and surgery. You have chosen oral appliance therapy to treat your particular problem and are aware that it may not be completely effective for you.

UNUSUAL OCCURRENCES

As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorption, non-vital teeth, muscle spasms, and ear problems are all possible occurrences.

Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

I consent to the taking of photographs and x-rays before, during and after treatment, and their use in scientific papers and demonstrations.

I certify that I have read, or had read to me, the contents of this form. I realize and accept any risks and limitations involved, and do consent to treatment.

Follow up Visits

Patients will be seen once a year for the life time of the appliance. There will be no charge for the first two months of evaluation. Then a fifty dollar charge will be applied for the next follow-up visits.

Date: _____

Patient: _____

Witness: _____

I understand that the only way to measure the efficacy of an intraoral sleep apnea appliance is via follow-up polysomnography, which I agree to do following fitting and adjustments.

Affidavit For Intolerance To CPAP

I have attempted to use the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s):

- Mask Leaks
- An Inability to get the Mask to Fit Properly
- Discomfort Caused by the Straps and Headgear
- Disturbed or Interrupted Sleep Caused by the Presence of the Device
- Noise From the Device Disturbing Sleep or Bed/Partner's Sleep
- CPAP Restricted Movements During Sleep
- CPAP Does Not Seem To Be Effective
- Pressure On The Upper Lip Causes Tooth Related Problems
- Latex Allergy
- Claustrophobic Associations
- An Unconscious Need to Remove the CPAP Apparatus at Night
- Other _____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Signed

Date _____