

Ohio Sleep Treatment: New Patient Paperwork

Patient Demographics

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Sex: Male Female

SSN: _____ (used for insurance verification purposes only)

Height: _____ inches Weight: _____ lbs.

Address: _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Best Way to Reach You (Please circle): Phone Email Text

Marital Status (Please circle): Single Widowed Divorced Married/Partner

Occupation: _____ How Long? _____

Emergency Contact: _____ Relationship: _____ Number: _____

Insurance Information

Primary Insurance Policy Information

Primary Insurance Company: _____

ID # : _____ Group # : _____

Complete the following if you are NOT the policy holder for your primary insurance:

Policy holder name: _____ Date of Birth: _____

Relationship to policy holder (Please circle): Spouse Child Parent Other: _____

Secondary Insurance Policy Information

Secondary Insurance Company: _____

ID# : _____ Group # : _____

Complete the following if you are NOT the policy holder for your secondary insurance:

Policy holder name: _____ Date of Birth: _____

Relationship to policy holder (Please circle): Spouse Child Parent Other: _____

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

Comprehensive Health Questionnaire

MEDICAL HISTORY

Current Medical Conditions

Please list current medical conditions for which you are being treated.

Diagnosis	Physician	Year	Treating
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HOSPITALIZATIONS/SURGERIES

List all hospitalizations and surgeries you have had. Please be thorough and include surgeries to remove your adenoids, tonsils, and/or wisdom teeth. Hospitalizations to be considered would be head injury, seizures, strokes, or heart conditions

Hospitalizations/Surgeries	Physician	Year	Treating
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MEDICATIONS

Please include prescriptions and non-prescription medications of all types, including sleep and non-sleep related.

Medication	Reason	Medication	Reason
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ALLERGIES

Please list any medical or drug allergies, excluding environmental

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

HEALTH HISTORY

Please circle "Y" for yes, and "N" for No

High Blood Pressure.....Y	N	Impaired Cognition(memory/concentration)...Y	N
Heart Disease.....Y	N	Insomnia.....Y	N
Stroke.....Y	N	Narcotic Use.....Y	N
Pulmonary Hypertension.....Y	N	Family History of Sleep Apnea.....Y	N
Type 2 Diabetes.....Y	N	(Females) Menopausal/Perimenopausal.....Y	N
Mood Disorders (anxiety/depression).....Y	N	(Males) Difficulty w/sexual function.....Y	N

SLEEP HISTORY

Describe your sleep problem in your own words:

If you had to pick one symptom to improve in regard to your general sleep or sleep apnea, what would it be?

When did this begin? _____

Have you received any treatment(s) for this problem(s)?

Have you ever completed a sleep study? Y N

Was it a Home Sleep Test or In-Lab Test? _____

If so, when? _____ (please provide an estimate if you aren't sure)

Who ordered it? _____ (please provide as much information as you can recall)

Describe your typical sleeping position. (back, side, stomach, move frequently, etc, if any physical limitations please elaborate):

Ohio Sleep Treatment: New Patient Paperwork

SLEEP SURVEY

Symptom	Description	Score
Snoring***	0 = no snoring 10 = very loud	
Gasping for/witnessed apneas	Total number of times per night	
Frequent nighttime awakenings	Total number of times per night	
Nocturia (the need to wake up 1 or more times during the night to urinate)	Total number of times per night	
Morning headaches	Total number of times per week	
Energy level while awake	0 = very tired 10 = very energetic	

**** If snoring is one of your chief complaints, please consider downloading the application, SnoreLab, onto your electronic device. This will allow you to objectively monitor your snoring throughout therapy and confirm that you are getting an improvement in your symptoms. Obtaining a baseline score before starting therapy is highly recommended. This will be an important step in your followup care.*

Consider other common symptoms of untreated Obstructive Sleep Apnea. Please check an “X” in the column on the right if you experience these at least once a month. We will discuss these and how they impact your life during your consultation.

Dry mouth upon awakening	
Fatigue	
Drowsy driving	
Night sweats	
Nighttime heartburn	
Inability to recall dreams	
Bruxism/nighttime clenching/grinding	
My sleep/snoring disturbs my bed partner	
Difficulty initiating sleep	
Unrefreshed Sleep	
Sexual dysfunction	
Mental/brain fog	
Memory Loss	

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

Epworth Sleepiness Scale

Patient's Name: _____ Date: _____

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

0 = would never 1 = slight chance 2 = moderate chance 3 = high chance

Situation	Chance of Dozing
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place (e.g. theatre, meeting)	_____
As a passenger in a care for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total Score: _____

Ohio Sleep Treatment: New Patient Paperwork

Affidavit for Intolerance to PAP

Patient Name: _____ DOB: _____

Check the following that applies:

I have **NOT** attempted to use PAP to manage my sleep related breathing disorder (apnea) and feel it would be intolerable to use for the following reasons (*check all that apply below*):

I **HAVE** attempted to use the PAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons (*check all that apply below*): **Reasons I**

CANNOT or WILL NOT be able to tolerate PAP

- Mask leaks
- An inability to get the mask to fit properly
- Discomfort 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 PAP apparatus at night Other
- (Please describe):

Based on my intolerance/inability to use PAP, I wish to have the alternative treatment, oral appliance therapy (OAT).

Patient Name: _____ Date: _____

Signature: _____

Ohio Sleep Treatment: New Patient Paperwork

Dental History Questionnaire

- 1. How would you describe your Dental Health Excellent Good Fair Poor
- 2. Have you ever had teeth extracted? Yes No
- 3. Do you wear removeable partials? Yes No
- 4. Do you wear removeable dentures? Yes No
- 5. Have you ever worn braces (orthodontics)? Yes No
- 6. Does your TMJ (jaw joint) click or pop? Yes No
- 7. Have you had TMJ (jaw joint) surgery? Yes No
- 8. Have you ever had gum problems? Yes No
- 9. Do you have dry mouth? Yes No
- 10. Have you ever had an injury to your head, face, neck, or mouth? Yes No
- 11. Are you planning to have dental work done in the next year? Yes No
- 12. Do you clench or grind your teeth? Yes No

If you answered “Yes” to any of the questions above, please indicate the question # and provide a brief explanation. For example, “#3. I have a fully removeable upper denture”

I am seeking treatment with a sleep orthotic appliance only. I understand that I am not a dental patient-of-record **Bradley Lynn, DDS; Sandra Pasquinelli, DDS; Anthony Falcone, DDS; Rahaf Sayed, DDS; Shbeena Shah, DDS; and Brandon Canfield, DDS.**

The importance of regular dental care has been explained to me and I understand that **Bradley Lynn, DDS; Sandra Pasquinelli, DDS; Anthony Falcone, DDS; Rahaf Sayed, DDS; Shbeena Shah, DDS; and Brandon Canfield, DDS** will not be responsible for providing my preventative or emergency dental needs. At this time, I choose to have my routine and necessary dental care completed in another office.

Patient Name: _____ Date: _____

Signature: _____

Ohio Sleep Treatment: New Patient Paperwork

Informed Consent for the Treatment of Sleep-Related Breathing Disorders With Oral Appliance Therapy Obstructive Sleep Apnea

You have been diagnosed by your Physician as requiring treatment for a sleep-related breathing disorder (SRBD), such as snoring, Upper Airway Resistance Syndrome (UARS), and/or Obstructive Sleep Apnea (OSA). SRBDs may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase your 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 (OAT) utilizes a custom-made, adjustable FDA-cleared appliance specifically made to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. In order to derive the benefits of OAT, the oral appliance must always be worn when you sleep.

Benefits of OAT

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. Additionally, durable medical equipment such as your oral appliance requires specific homecare, maintenance, and periodic replacement.

Possible Risks, Side-Effects, and Complications of OAT

With an oral appliance, some patients experience excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, and short-term bite changes. It is possible to experience dislodgement of dental restorations, such as fillings, crowns, and dentures. 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 are typically progressive and may or may not be fully reversible once OAT is discontinued. It is mandatory for you to complete follow-up visits with the dentist who provided your oral appliance to ensure proper fit and optimal positioning. If unusual symptoms or discomfort occur or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further. Follow-up assessments are necessary to assess your health and monitor your progress. Once your oral appliance is in an optimal position, a reevaluation visit with your referring physician is necessary to verify that the oral appliance is providing effective treatment.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include positive airway pressure (PAP) therapy, various surgical and implant procedures, and positional therapy (which prevents patients from sleeping on their back instead of their side). The risks and benefits of these alternative treatments should be discussed with your physician who diagnosed your condition and prescribed treatment. It is your decision to choose OAT alone or in

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

combination with other treatments to treat your sleep-related breathing disorder. However, none of these may be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to Ohio Sleep Treatment.

450 Alkyre Run Dr Suite 300 Westerville, OH 43082

SleepTreatmentOH.com

Ohio Sleep Treatment: New Patient Paperwork

Privacy Policy Acknowledgement

Ohio Sleep Treatment follows all guidelines with your Personal Health Information (PHI) and will ONLY use that information as described in the 5 page “Notice of Privacy Practices”.

You may read through it if you request a copy. Please let us know if;

- You have any questions about this notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

Your Responsibilities:

- Provide accurate and complete information concerning your present medical conditions, past illnesses or hospitalization and any other matters concerning your health.
- Notify us if your insurance, address, phone number. etc. changes.
- Tell your provider(s) if you do not completely understand your plan of care.
- Follow the Providers' instructions.

My signature below indicates I understand the Privacy Practices and my Responsibilities as a patient of Ohio Sleep Treatment.

Patient Name: _____ Date: _____

Signature: _____

Ohio Sleep Treatment: New Patient Paperwork Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Purpose: Ohio Sleep Treatment is committed to protecting Health Information about you. Ohio Sleep Treatment and its employees, non-employees, and all their affiliated entities follow the privacy practices described in this Notice. Ohio Sleep Treatment maintains your health information in records that are kept in a confidential manner, as required by law. Ohio Sleep Treatment must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: Ohio Sleep Treatment has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with sleep physicians or other consultants to make a diagnosis. Ohio Sleep Treatment may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, Ohio Sleep Treatment may use and disclose your health information to improve the quality of care, and for education and training purposes of Ohio Sleep Treatment employees or affiliates.

How Will Ohio Sleep Treatment Use and Disclose My Health Information?

Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

- Family members or close friends involved in your care or payment for treatment. (*)
- Advanced MD is a secure computer system for health care providers to share your health information to support treatment, healthcare operations and continuity of care. Your record in Advanced MD includes medicines (prescriptions), lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included are your full name, birth date and social security number. All information contained in Advanced MD is kept private and used in accordance with applicable state and federal laws and regulations.
- Appointment reminders.
- To contact you regarding treatment alternatives.
- Public health activities, including disease prevention, injury, or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state, or local law.

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or another lawful request.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

Your Authorization Is Required for Other Disclosures. Your authorization will be required for most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute a sale of protected health information. Except as described, we will not use or disclose your medical information without written permission. For example, we will not use your photographs for presentations outside Ohio Sleep Treatment without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

You Have Rights Regarding Your Health Information. You have the following rights regarding your medical information, if requested on the form(s) provided by Ohio Sleep Treatment:

- Right to request restriction: You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not.
- Right to confidential communications. You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- Right to inspect and copy: You have the right to review and obtain a copy of your medical or health record. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen Ohio Sleep Treatment. Ohio Sleep Treatment will comply with the outcome of the review.

Rights and Responsibilities

You have the right to:

- Be treated in a dignified and respectful manner and to receive reasonable responses to reasonable requests for service.
- Effective communication that provides information in a manner you understand, in your preferred language with provisions of interpreting or translation services, at no cost, and in a manner that meets your needs in the event of vision, speech, hearing or cognitive impairments. Information should be provided in easy to understand terms that will allow you to formulate informed consent.

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

- Respect for your cultural and personal values, beliefs and preferences.
- Personal privacy, privacy of your health information and to receive a notice of the facility's privacy practices.
- To access, request amendments to and obtain information on disclosures of your health information in accordance with law and regulation within a reasonable time frame.
- Care or services provided without discrimination based on age, race, ethnicity, religion culture, language, physical or mental disability, and socioeconomic status, sex, sexual orientation, and gender identity or expression.
- Participate in decisions about your care. including developing your treatment plan
- Refuse care, treatment or services in accordance with law and regulation.
- Receive information about the outcomes of your care, treatment, and services, including unanticipated outcomes.
- Give or withhold informed consent when making decisions about your care, treatment, and services.
- Receive information about benefits, risks, side effects to proposed care, treatment, and services; the likelihood of achieving your goals and any potential problems that might occur during treatment and services and any reasonable alternatives to the care, treatment and services proposed.
- Give or withhold informed consent to recordings, filming or obtaining images of you for any purpose other than your care.
- Be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.
- An environment that is safe, preserves dignity, and contributes to a positive self-image.
- Examine and receive an explanation of the bill for services. regardless of the source of payment
- Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by Ohio Sleep Treatment. Ohio Sleep Treatment is not required to accept the amendment.
- Right to accounting of disclosures. You may request a list of the disclosures of your health information that have been made to persons or entities during the past six (6) years prior to the request, except for disclosures for health care treatment, payment and operations, and disclosures based on patient authorization, or as required by law. After the first request, there may be a charge.
- Right to restrict certain disclosures to a Health Plan. You may request a restriction of certain disclosures of your protected health information to a health plan if you have paid out of pocket in full for the health care item or service.
- Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this.

Ohio Sleep Treatment: New Patient Paperwork

Requirements Regarding This Notice.

Ohio Sleep Treatment is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. Ohio Sleep Treatment may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the office (address below), or to your physician. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications and/or accidental injury.

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509 F
HHH Building Washington, D.C. 20201

We will not penalize or retaliate against you in any way for making a complaint to Ohio Sleep Treatment or to the Department of Health and Human Services. We will notify you in the unlikely event of a breach of your unsecured protected health information.

Patient's Privacy and Confidentiality

I acknowledge receipt of the office's privacy policies. This includes a summary of the HIPAA federal law and the applicable state laws.

Patient Obligations and Acknowledgements

- I understand the explanation of the proposed treatment. Further additional communication tools such as videos, pamphlets or articles may be available at my request. I have read this document in its entirety and have had an opportunity to ask questions. Each of my questions has been answered to my satisfaction. If I do not understand this document, I have been offered this document in a different language or have been offered a language interpreter. My family alone is not acceptable to be my interpreter.
- I agree that regularly scheduled follow-up appointments with my dentist (oral appliance provider) are essential. These visits will attempt to minimize potential side effects and to maximize the likelihood of management of my OSA.
- I understand that I must schedule a re-evaluation visit with my physician to verify that the oral appliance is providing effective treatment.
- I will notify this office of any changes to the oral appliance, my bite, my teeth, and my medical condition(s).
- I consent to treatment with a custom-made, adjustable, FDA-cleared oral appliance to be delivered and adjusted by my dentist (oral appliance provider). I agree to follow all post-delivery and home care instructions.

Please continue to the next page if information is requested

Ohio Sleep Treatment: New Patient Paperwork

- I understand that if I discontinue OAT, I agree to inform and follow up with my physician and dentist (oral appliance provider).
- I understand that refusing to participate and cooperate as stated herein will put my health at risk.
- I understand that I must maintain my oral appliance and my oral health through regularly scheduled follow up appointments with my general dentist and my oral appliance provider dentist, if not the same

Please sign and date this form below to confirm your agreement with the above statements.

Patient Name: _____ Date: _____

Signature: _____

Witness Name: _____ Date: _____

Signature: _____

If a patient is a minor, please sign as Parent or Legal Guardian

Parent or Legal Guardian Name: _____ Date: _____

Signature: _____