Front Range Dental Sleep Medicine

ANDREW T SMITH, DDS

SPECIALTY TRAINED DENTIST: PRACTICE LIMITED TO
INTRAORAL APPLIANCE THERAPY FOR SLEEP APNEA & SNORING
OROFACIAL PAIN, TEMPOROMANDIBULAR JOINT DISORDERS (TMJ) & RELATED HEADACHES

PATIENT INFORMATION

Patient's Name:_______________________________________Date:_______________________________________

Social Security #:__________________________DOB:________________________Age:______________________

Street Address:____

City:____________________________ State_________Zip Code_____________Phone:________________________

Email:____Occupation:_________________________

Preferred Pharmacy:_______________________________Pharmacy Number:________________________________

Purpose of Visit:____

____

Whom may we thank for referring you to this office? ____

Emergency Contact______________________ Phone #_____________________ Relationship_________________

Health History
(Mark all that apply)

Heart Murmur	Endocarditis	Heart disease	Pacemaker	High blood pressure	Tuberculosis	Kidney disease
Liver disease	HIV or AIDS	Asthma	Cancer	Heart Surgery	Mitral valve prolapse	Bleeding Disorder
Anemia	Diabetes	Epilespy/ Seizure	Pregnant	On Birth control	Hepatitis	

*Other: Explain*____

Allergies: ____

Name of your Primary Care Physician_____________________________________Phone_______________________

INSURANCE INFORMATION

Insurance Company_______________________________ ID Number_______________________________________

Group/Policy Number_____________________Insured's Birthdate_________Insured's Name____________________

LIFESTYLE AND PHYSICAL ACTIVITIES
(Please check the appropriate response)

Do you use Tobacco? __No __Yes Type: __Cigarettes __Packs per day __Cigars __Smokeless

Drink alcohol containing beverages? __No __Yes Type consumed __Beer __Wine __Liquor __Drinks per week

Engage in high risk activities (please describe):____

Exercise: _No _Yes, Please Describe:____

Do you have a lot of stress in your life? __No __Yes

AUTHORIZATION FOR INTIAL VISIT

I understand that the visit scheduled upon completion of this document is for an evaluation and consultation. The visit will consist of a review of my history and any reports that are available and clinical examination followed by a consultation and discussion of the findings and he recommended course of treatment/action.

Signature:____

AUTHORIZATION TO SUBMIT INSURANCE CLAIM

I authorize Dr. Smith to submit claims on my behalf for payment of services rendered to the named insurance company on this form. Furthermore, I authorize the insurance company to pay benefits directly to Dr. Smith on my behalf. I understand that if the insurance company denies payment of the claims, or if payment is directly mailed to me, I become responsible for the payment of the services rendered by Dr. Smith. After 90 days I accept full responsibility for payment to Dr. Smith.

Signature:____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Smith to release information relative to my medical history, diagnosis and treatment to the named insurance company or to any health care provider related to my treatment.

Signature:____

MEDICATION LISTING

Medication Name	Dose (mg)	Taken how often	Route	Reason for taking	Currently Taking
			____Oral ____Topical ____Injection		Yes No
			____Oral ____Topical ____Injection		Yes No
			____Oral ____Topical ____Injection		Yes No
			____Oral ____Topical ____Injection		Yes No
			____Oral ____Topical ____Injection		Yes No
			____Oral ____Topical ____Injection		Yes No
			____Oral ____Topical ____Injection		Yes No

Reviewed

Date: _________ Date: _________ Date: _________ Date: _________ Date: _________

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NOTICE OF PRIVACY PRACTICES

Patient Name:____Date of Birth:______________

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) this office may use your personal health information for the purpose of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing the consent form. You may request restrictions on the "restriction request" form, which we will provide if needed. You may revoke this consent at any time by signing and dating the revocation form, which we will provide if needed.

ACKNOWLEDGEMENT / CONSENT OF NOTICE OF PRIVACY PRACTICES

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also acknowledge that I am informed of Dr. Smith's Practice Privacy Policy and have been offered a copy.

____

Signature of patient or patient representative Date

COMMUNICATION REQUEST

The phone numbers listed below are the only place(s) my personal health information may be left as a message or as voicemail. This includes appointment times, results of testing, insurance status and/or any other personal communication that needs to take place that may contain personal health information and is a part of my healthcare in this office.

Phone Number	Location (Circle One)		
____________________	Home	Work	Cell
____________________	Home	Work	Cell
____________________	Home	Work	Cell

____

Signature of patient or patient representative Date

Additional Communication

I give my permission for medical information to be discussed with:

☐ Parents (if under 18) ☐ Spouse/Partner

____

Signature of patient or representative

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Financial and Office Policy

Welcome to Front Range Dental Sleep Medicine. We are dedicated to provide you the best care possible. Following are our current office policies;

1. We will bill your insurance claims to your insurance carrier as a courtesy providing we have your current and complete insurance on file. If current and accurate information is not on file you will become responsible for the payment of services rendered.

2. We accept payment from insurance companies but you are personally responsible for any copayments, coinsurance and deductibles. If copayments are not made at the time of the visit a $10 fee will be assessed to your account for which you will be personally responsible.

3. Should your insurance company require a referral it is your responsibility to obtain a referral from the primary care physician. This needs to be on file in our office prior to your appointment. If there is no referral on file you will become responsible for the payment at the time of the visit.

4. As a courtesy we pre-authorize medical devices and treatments per Dr. Smith's recommendations. As a courtesy we make every effort to check on insurance coverage and benefits. However, it is your responsibility to know your coverage and benefits and personally check on them. Your insurance policy is a contract between you and your insurance company.

5. In the event that insurance does not pay for your device or services provided you will be responsible for the remaining fees.

6. It is customary for a deposit to be collected before an oral appliance is fabricated. This may occur even if you have met your out-of-pocket expenses, and will be refunded when your insurance provides the benefit for the treatment. This amount is due at the time of service.

7. Account balances are due within 30 days of billing. If you are unable to make payment in full, please contact our office to make payment arrangements.

8. A failed appointment without 48 hours notice will result in a $50 fee assessed to your account and will become your personal responsibility.

9. Dr. Smith makes every effort to run on time and we appreciate you being on time for your appointment. If you are more than **10 minutes late** you may not be able to be seen. New patients please be **15 minutes early** to allow time to complete your paperwork.

Please sign below to confirm you have read and understand our financial policy.

_______________________________________ ____________________

Name (Print) Date

____

Patient Signature or Responsible Party

Berlin Questionnaire

CATEGORY ONE:

1 Do you snore? Yes No Don't Know

2 How loud is your snoring?

As loud as breathing

As loud as talking

Louder than talking

Loud enough to be heard in the next room.

3 How Often do you snore?

Nearly every day

3–4 × /week

1–2 × /week

1–2 × /month

Hardly ever

4 Has your snoring ever bothered other people? Yes No

5 Has anyone noticed you stop breathing when you are asleep?

Nearly every day

3–4 × /week

1–2 × /week

1–2 × /month

Hardly ever

CATEGORY TWO

1 After sleep, are you fatigued?

3–4 × /week

1–2 × /week

1–2 × /month

Hardly ever

2 While awake, are you fatigued?

3–4 × /week

1–2 × /week

1–2 × /month

Hardly ever

3 Have you ever fallen asleep or nodded off while driving a vehicle?

Nearly every day

3–4 × /week

1–2 × /week

1–2 × /month

Hardly ever

CATEGORY THREE:

1 Do you have hypertension? Yes No

2 BMI=

Category I is positive with 2 or more positive responses ☐

Category II is positive with 2 or more positive responses ☐

Category III is positive with 1 or more positive responses or BMI>03 ☐

Two or more positive categories indicates a high likelihood of sleep disordered breathing

Epworth Sleepiness Scale

Name:______________________________Date:__________________________

Age:___________________ Gender: MALE FEMALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the <u>most appropriate number</u> for each situation:

0 = Would <u>never</u> doze

1 = <u>Slight</u> chance of dozing

2 = <u>Moderate</u> chance of dozing

3 = <u>High</u> chance of dozing

Situation	**Dozing Chance**
Sitting and reading………………………………………………………………..	
Watching TV…………………………………………………………………………	
Sitting inactive in public place (e.g theatre or a meeting)…………..	
As a passenger in a car for an hour without a break………………..	
Lying down to rest in the afternoon………………………………………….	
Sitting and talking to someone………………………………………………..	
Sitting quietly after a lunch without alcohol……………………………	
In a car, while stopped or. few minutes in traffic……………………..	
Total:………………………………………………………………………………………	

Score:
Normal Range 0-10
Borderline 10-12
Abnormal 12-24

STOP BANG

Screening for :
Obstructive Sleep Apnea

Answer the following questions to find out if you are at risk for Obstructive Sleep Apnea.

STOP

S (snore)	Have you been told that you snore?	YES / NO
T (tired)	Are you often tired during the day	YES / NO
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing?	YES / NO
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	YES / NO

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI)	Is your body mass index greater than 28?	YES / NO
A (age)	Are you 50 years old or older?	YES / NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	YES / NO
G (gender)	Are you a male?	YES / NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea