Patient Registration

Please fill in completely

Name:		Date:
Gender: Male Female		
Address:		
City:	State:	Zip:
Home Ph: ( )	Work Ph: ( )	Cell Ph: ( )
E-Mail address:		
Preferred form of contact:		
Birth date:		
Social Security Number:		
Employer:		
How did you hear about our office?		

Present Dentist:		
Address:		
Phone: ( )		
City:	State:	Zip:
Date of last visit:		

Present Physician:		
Address:		
Phone: ( )		
City:	State:	Zip:
Are you now under the care of a physician? Yes No		
If yes, for what reason?		

Health Insurance Information

Medical Insurance Company:
ID#:
Group #:
Subscriber's Name:
Subscriber's Soc. Sec.#:
DOB:

Records release: I hereby authorize Dental Sleep Center at Keller Dentistry to release my information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patient (or parent if minor)

Signature Date

Office Policies

THANK you for choosing us as your oral health and dental provider. We would like you to take a moment to review our office policies. Please feel free to ask our staff any questions that you may have regarding our policies.

MISSED APPOINTMENTS: An appointment to visit our office reserves the time exclusively for you. We understand that sometimes appointments need to be changed. Kindly notify our office at least *48 hours* before your appointment if you have to make a change, so that we may offer that time slot to someone else. Failing to keep a reserved appointment will result in a $100.00 charge. No fees will be charged for rescheduling an appointment provided *48 hours* or more notice is given.

WE respect your desire to make a responsible decision regarding your treatment and every effort will be made to discuss the benefits, alternative treatments, possible risks, and financial aspects of your treatment so that you may make an informed decision. Acceptance of the treatment implies that you understand and consent to all treatments and fees involved.

AS a courtesy, we will submit your dental insurance claim and accept assignment if the information we need from you is provided in a timely manner. Your treatment will never be compromised to satisfy the usual and customary fees that your insurance company may impose. It is important, however, for you to understand that insurance benefits generally do not cover the entire fee and that the difference will be your responsibility. Dental insurance does not absolve you of the financial responsibility for the treatment rendered. Our office staff will gladly be of assistance should you have any questions about your treatment or related costs.

YOUR financial obligation necessary to complete treatment is based upon an estimate derived from our examination and diagnostic films. Should additional unforeseen necessary procedures arise as treatment progresses, this estimate may have to be revised. You will be consulted before any unexpected treatment is undertaken.

PAYMENTS are due on the day that services are rendered. If you have dental benefits your estimated portion is expected. Cash, check or major credit cards are accepted by our office for your convenience.

Should your balance remain unpaid after 60 days, your account will become delinquent. A late charge will accrue on the account balance at the rate of 1.5% per month (18% annually). You will receive a letter stating that in 30 days your account will be reported to TRW and collection proceedings may begin. A bookkeeping fee of $ 75.00 will be charged to your account when TRW is notified. Any fees, including court and attorney fees, will be the responsibility of the guarantor. There is a $ 40.00 handling and bookkeeping fee for any returned checks.

FAILURE to sign this agreement does not negate your financial obligation for any previous or future treatment.

We look forward to welcoming you and your family to our dental practice and we thank you for the confidence you have bestowed on us to treat your dental needs.

I understand and agree to abide by the above office policies:

______________________	______________________	______________
PRINT NAME	SIGNATURE	DATE

Office (805) 527-2266
Fax (805) 527-2269

Meir N Keller DDS MS DABDSM
2489 Tapo St, Simi Valley, CA 93063

office@kellerdsm.com
www.kellerdsm.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: ____

Address: ____

Telephone: ____________________________ Email: __________________________________

Social Security Number: ____

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important natters about your protected health information. A copy of our Notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Cynthia
Telephone: (805) 527-2266 Fax: (805) 527-2269
Email: office@kellerdsm.com
Address: 2489 Tapo St, Simi Valley, CA 93063

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ________________________________, have had full opportunity to read and consider the content of this consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: ___________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Office (805) 527-2266
Fax (805) 527-2269
Meir N Keller DDS MS DABDSM
2489 Tapo St, Simi Valley, CA 93063
office@kellerdsm.com
www.kellerdsm.com

Meir Keller, D.D.S., M.S., A Dental Corporation & Associates

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.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the

extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you up to $ 50.00 for staff time to locate and copy your x-rays, treatment chart and health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your chart information in that format. If you prefer, we will prepare a summary or an explanation of your treatment record for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Cynthia or Claritza

Telephone: 805-527-2266 Fax: 805-527-2269

E-mail: Office@kellerdsm.com

Address: 2489 Tapo Street, Simi Valley, California 93063

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, ______________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

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Date ________________

Physician Name: ___________________________

Physician Address: _________________________

____

Release of Records Authorization

The following information is for records on:

Patient's name: ____

Birthdate: ______________________________

Address: ____

____

Telephone: ____

I hereby authorize: ____

to release records to: Dr. Meir Keller ________________________________

Information to be released:

- ❑ Dental records
- ❑ Patient report(s) prepared from this office
- ❑ Test results
- ❑ X-Rays
- ❑ Polysomnography (PSG's)

Records are needed for:

- ❑ Coordinating Care of Oral Appliance Therapy for Obstructive Sleep Apnea
- ❑ Insurance
- ❑ Communication with your other health care providers
- ❑ Legal Purposes
- ❑ Continuing care
- ❑ Other ____

I understand that the information to be released may include, history, diagnoses, and or treatment of therapy related to this dental office. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization will expire 90 days from the date of signature. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Patient Signature: ____ Date ____________________

Prohibition of redisclosure: This information has been disclosed to you from records, which are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of dental or other information is not sufficient for this purpose.

Personal Medical History with Review of Systems

Name ______________________________ Date ______________

Do you have or have you had any pain in any of the following areas?
Please circle: Jaw Ear Face Neck Teeth Headaches Other: (specify) ______________________

Does your jaw make any of the following noises?
Please circle: Clicking Popping Rubbing Grinding Crunching Other: ____________

Have you received treatment for any TMJ, head, or neck symptoms? Yes No
When was your last dental visit? ______________________________________
Have you been told that you have periodontal (gum) disease? Yes No
Do you have any existing problems with your teeth? Yes No Describe: _______________
Is any dental treatment planned? Yes No

General

Change in Appetite	Y	N
Fever	Y	N
General Weakness	Y	N
Marked Weight Change	Y	N
Night Sweats	Y	N
Polyuria (frequent urination)	Y	N
Recent Trauma or Injury	Y	N
Unusual Weakness	Y	N
Chronic Fatigue Syndrome	Y	N
Itch	Y	N
Hepatitis	Y	N
Tumors/cancer	Y	N
HIV/AIDS	Y	N

Allergies

Dairy	Y	N
Dust	Y	N
Hay Fever	Y	N
Latex	Y	N
Penicillin	Y	N
Sulfa drugs	Y	N
Wheat	Y	N

Neurological

Confusion	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Muscle weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Tremor	Y	N
Alzheimer's Disease	Y	N
Multiple Sclerosis (MS)	Y	N

Skin

Acne	Y	N
Frequent bleeding	Y	N
Bruising	Y	N
Eczema	Y	N
Lesions	Y	N
Psoriasis	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Changes	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in hearing	Y	N
Change in smell	Y	N
Dysphagia (difficulty swallowing)	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hearing loss	Y	N
Visual changes	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Hoarseness	Y	N
Sinus Problems	Y	N
Tinnitis (ringing in ears)	Y	N

Cardiovascular

Condition	Y	N
Coronary Artery Disease	Y	N
Chest pain	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heartbeat	Y	N
Tachycardia (rapid heartbeat)	Y	N

Respiratory

Condition	Y	N
Asthma	Y	N
Bronchitis	Y	N
Chest pressure	Y	N
Congestion	Y	N
Cough	Y	N
Emphysema	Y	N
Pneumonia	Y	N
Pulmonary embolism	Y	N
Shortness of breath	Y	N
Tuberculosis	Y	N

Gastrointestinal

Condition	Y	N
Black or bloody stool	Y	N
Constipation	Y	N
Diarrhea	Y	N
Reflux/GERD	Y	N
Irritable Bowel Syndrome	Y	N
Stomach pain	Y	N
Ulcers	Y	N
Vomiting	Y	N

List any medications you are taking:	Dosage
List any Vitamins/Supplements you are taking:	

Genitourinary

Condition	Y	N
Frequent Urination	Y	N
Hematuria (blood in urine)	Y	N
Incontinence	Y	N
Kidney Infections	Y	N
Kidney Stones	Y	N
Kidney Disease	Y	N
Prostate problems	Y	N
Cervical/Uterine/Ovarian/Breast Cancer	Y	N
Currently pregnant?	Y	N

Psychiatric

Condition	Y	N
ADD/ADHD	Y	N
Anxiety	Y	N
Autism	Y	N
Depression	Y	N
Disorientation	Y	N
Excess Stress	Y	N
Hallucination	Y	N
Memory problems	Y	N
Eating Disorders	Y	N
Chemical Dependency	Y	N

Musculoskeletal

Condition	Y	N
Back pain	Y	N
Fibromyalgia	Y	N
Joint pain	Y	N
Limited range of motion	Y	N
Muscle Atrophy	Y	N
Muscle pain	Y	N

Social History

Question	Y	N
Do you smoke?	Y	N
How many packs a day?		
Do you consume alcoholic beverages?	Y	N

_______ Drinks per day/week/month

List any surgeries you have had:

I certify that the above information is correct to the best of my knowledge.

Patient signature: ____Date: _______________

Initial Evaluation Questionnaire

Name Date

Current Therapies:

Have you attempted CPAP therapy? Yes No

If yes, are you able to use it at least 5 nights a week
(4 or more hours per night)? Yes No

Have you undergone any surgical attempts to correct your sleep apnea? Yes No

Would you prefer an oral device? Yes No

Have you tried any of the following conservative methods of improving your sleep breathing? (Please check)

- ☐ Weight loss
- ☐ Positional therapy: Avoiding sleeping on our back during sleep (the supine position)
- ☐ Abstaining from the use of alcohol and/or sedatives before bedtime

Patient Sleepiness Scale

	Never	Rarely	Sometimes	Often
1. Have you snored, or have you been told that you do?				
2. Have you had choking or shortness of breath sensations at night?				
3. Have you woken up during sleep?				
4. Have you had morning fatigue or fogginess or woken up feeling unrefreshed?				
5. Have you woken up with a headache?				
6. Have you had chronic sleepiness, fatigue or weariness that you can't explain?				
7. Have you fallen asleep during the day, particularly when not busy?				
8. Have you fallen asleep during the day against your will?				
9. Have you had to pull off the road while driving due to sleepiness?				
10. Have you been more irritable and short-tempered?				

11. Have you felt your memory and/or intellect is impaired? Yes No

12. Have you been told that you stop breathing while asleep? Yes No

13. Have you had a sleep lab study? Yes No

14. Do you have difficulty breathing through your nose? Yes No

15a. Have you gained weight recently? Yes No

15b. About how much?

16. What other doctors have you seen about your snoring or sleep apnea?

17. What professional advice or treatment have you received about your snoring or sleep apnea?

Bed Partner/Witness Screening Questionnaire for OSA

Name

Person completing form Date

Please answer the following questions as they pertain to your bed partner in the past month.

	Question	Yes	No	Don't Know
1.	While sleeping, does your partner:			
	Snore more than half the time?	Yes	No	Don't Know
	Always snore?	Yes	No	Don't Know
	Snore loudly?	Yes	No	Don't Know
	Have "heavy" or loud breathing?	Yes	No	Don't Know
	Have trouble breathing, or struggle to breathe?	Yes	No	Don't Know
2.	Have you ever seen your partner stop breathing during the night?	Yes	No	Don't Know
3.	Does your bed partner ever have snorting or choking episodes during the night?	Yes	No	Don't Know
4.	Does your partner:			
	Tend to breathe through the mouth?	Yes	No	Don't Know
	Have a dry mouth on waking up in the morning?	Yes	No	Don't Know
	Occasionally wet the bed?	Yes	No	Don't Know
5.	Have you ever experienced your partner:			
	Grinding their teeth during the night?	Yes	No	Don't Know
	Have twitching or kicking of their legs or arms?	Yes	No	Don't Know
6.	Does your partner:			
	Wake up feeling unrefreshed in the morning?	Yes	No	Don't Know
	Have a problem with sleepiness during the day?	Yes	No	Don't Know
7.	Has a friend, coworker, or supervisor commented that your partner appears sleepy during the day?	Yes	No	Don't Know
8.	Is it hard to wake your partner up in the morning?	Yes	No	Don't Know
9.	Does your partner wake up with headaches in the morning?	Yes	No	Don't Know
10.	Is your partner overweight?	Yes	No	Don't Know

Sleep Disorder Symptoms Assessment

Date ______________

Name:____

Date of Birth: (M/D/Y) _____/_____/_____ Gender: M____F_____

Insurance Plan: ____

FOR OFFICE USE:
Height:____________________________
Weight:____________________________
BMI: ______________________________
Neck Size: _________________________
Blood Pressure: _____________________

Please check any of the following you may have:			
☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight

Snoring:				Score
1. Do you snore often (3 or more nights a week)?	☐ YES	☐ NO	☐ Don't Know	____ Yes=1
2. Is your snoring loud enough to be heard through a closed door or annoy other people?	☐ YES	☐ NO	☐ Don't Know	____ Yes=1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?	☐ YES	☐ NO	☐ Don't Know	____ Yes=2
			(sum of all numbers checked above) Total Score	

Epworth Sleepiness Scale:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place (meeting, theater)?	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?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			(sum of all numbers checked above) Total Score	

CPAP:
Are you currently using CPAP? ☐YES ☐NO ☐If yes, for how long? _________

0 – 10 Normal

11-14 Mild

15-17 Moderate

18-24 Severe

STOP-BANG Questionnaire

What is Obstructive Sleep Apnea (OSA)?

It is when your breathing stops or slows down while you are sleeping.
If you snore loudly or gasp for air when you sleep, or you are always tired, you may have OSA.

OSA is often present with other diseases. If OSA is overlooked, it could be bad for your health.

- 43 million Americans currently have OSA
- 50% of patients with diabetes have OSA
- 30% of patient with high blood pressure have OSA

Complete the questionnaire below to know if you are at risk of OSA.

Patient Information	
Name:	Date:
Male/Female (M/F):	Age (years):
Height ______ Feet ______ Inches	Body Mass Index (BMI):
Weight (pounds):	Neck or collar size (in inches; office staff can measure):

STOP-BANG	YES	NO
Do you **S**NORE loudly (i.e., louder than talking or loud enough to be heard through closed door(s)?		
Do you often feel **T**IRED, fatigued, or sleepy during the day?		
Has anyone **O**BSERVED that you have stopped breathing while sleeping?		
Do you have or are you being treated for high blood **P**RESSURE?		
BMI more than 35 kg/m^2?		
Are you more than 50 years of **A**GE?		
Is your **N**ECK 17 inches or greater for men (16 inches for women)?		
Male **G**ENDER?		

Yes to 3 or more questions means you are at high risk.

INFORMED CONSENT FOR THE TREATMENT OF SLEEP-RELATED BREATHING DISORDERS WITH ORAL APPLIANCE THERAPY

Patient's Name Date

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 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 Oral Appliance Therapy

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 Oral Appliance Therapy

With an oral appliance, some patients experience excessive drooling, 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. 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 may or may not be fully reversible once OAT is discontinued. These changes are likely to continue to worsen with continued use of the device.

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 asses your health and monitor your progress.

Oral appliances can wear and break. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use of an oral appliance is a hazard to your health and can lead to a heart attack, or stroke and even death. See Dr. Keller before discontinuing use and for recommendations for alternative therapy such as Continuous Positive Airway Pressure (CPAP) and/or surgery.

Once your oral appliance is in an optimal position, a post-adjustment assessment by your 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 on 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 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 this 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.

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

1. I understand the explanation of the proposed treatment. Further additional communication tools such as videos, pamphlets or articles may be available at my request.
2. 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.
3. 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.
4. I understand that I must schedule a post-adjustment assessment with my Physician to verify that the oral appliance is providing effective treatment.
5. I will notify this office of any changes to the OAT, my teeth and my medical condition(s).
6. I understand that I must maintain my oral appliance through regularly scheduled follow-up appointments with my general dentist and my oral appliance provider dentist, if not the same.
7. I understand that if I discontinue OAT, I agree to inform and follow-up with my Physician and Dentist (oral appliance provider).
8. I understand that refusing to participate and cooperate as stated herein will put my health at risk.
9. 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 homecare instructions.

Please sign and date this form below to confirm your agreement with the above statements. You will receive a copy of this document for your records, and it will be included in your patient records.

____

Patient Signature Date

____

Print Name

____

Witness Signature Date

____

Print Name

Dentist Acknowledgement

____

Signature Date

____

Print Name

Date _______________

Patient Name ______________________________________

DOB: __________________________

Insurance ID#: _____________________________________

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):
- ❑ I have not attempted to use nasal CPAP and I choose not to use nasal CPAP to manage my sleep related breathing disorder (apnea) 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).

Patient Signature: ____ Date: _________________