

21st Century Dental Sleep Screening Questionnaire

Patient Name: _____ Preferred Name: _____

Male Female Married Single Child

Home Address: _____
Street Apartment #

Birth Date: _____ Social Security #: _____ Driver's License # _____ State _____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ Pager/Cell: _____

E-Mail Address: _____

Employer Name: _____ Position: _____ How long there?: _____

Weight: _____ Height: _____ Age: _____

Please list other members of your immediate family who are patients in our office _____

Referral Information

Can we thank someone for referring you?

Family member _____

Coworker _____

Friend _____

Doctor _____

Or did you find us on your own?

Our award winning website.
(How did you find it?) _____

____ Mailer

____ Yellow Pages

____ Irving Journal

____ Irving Parent

Other _____

Medical Insurance Information

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Social Security #: _____
Last First MI

Insurance Company: _____ Phone: _____

Member# _____ Plan # _____ Group #: _____

Insurance Address: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Dental Insurance Information

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Social Security #: _____ Group #: _____
Last First MI

Insurance Company: _____ Phone: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

*Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

Date: _____

Signature of patient, parent or guardian _____

21st Century Dental
What's the chance you will doze off
in the following situations?

Sitting and Reading

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

Watching TV

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

Sitting inactive in a public place, such as a theater or meeting

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

As a passenger in a car for an hour without a break

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

Lying down to rest in the afternoon when circumstances permit

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

Sitting and talking to someone

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

Sitting quietly after a lunch without alcohol

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

In a car, while stopped for a few minutes in traffic

- 0 - No Chance of Dozing
- 1 - Slight Chance of Dozing
- 2 - Moderate Chance of Dozing
- 3 - High Chance of Dozing

Add your scores to get a total _____

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.

Referring Doctor: _____ Phone: _____

What are the chief complaints for which you are seeking treatment?

Please **NUMBER** the complaints with #1 being the primary reason for seeking treatment.

____ Frequent, heavy snoring

____ Morning Hoarseness

OR ____ Which affects the sleep of others

____ Morning Headaches

____ Significant daytime drowsiness

____ Swelling in ankles or feet

____ I have been told, "I stop breathing" when sleeping

____ Nocturnal teeth grinding

____ Gasping when waking up

____ Jaw Pain

____ Nighttime choking spells

____ Jaw Clicking

____ Feeling unrefreshed in the morning

____ Other: _____

Sleep Center Evaluation

Have you ever had an evaluation at a sleep Center?

If yes: Sleep Center Name: _____

Location: _____ Date: _____

For Office Use Only

The Evaluation confirmed a diagnosis of:	<input type="checkbox"/> Mild
	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Severe
The evaluation showed an RDI of _____	And an AHI of _____

CPAP Intolerance

(Continuous Positive Airway Pressure Device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- Mask leaks
- I was unable 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 my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- Pressure on the upper lip causing tooth related problems
- A latex allergy
- Claustrophobic associations
- An unconscious need to remove the CPAP apparatus at night
- Other: _____

Other Therapy Attempts

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

List any medications that may have caused an allergic reaction:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Metals | <input type="checkbox"/> Other:_____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Plastic | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sedatives | _____ |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sleeping Pills | |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa Drugs | |
| <input type="checkbox"/> Local Anesthetics | | |

List any medications you are currently taking:

- | | | |
|--|---|---|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Heart medication | <input type="checkbox"/> Other:_____ |
| <input type="checkbox"/> Anti-inflammatory (non-steroid) | <input type="checkbox"/> High blood pressure medication | _____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Insulin | _____ |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Muscle relaxants | _____ |
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Nerve Pills | |
| <input type="checkbox"/> Bisphosphonates | | |

Medical History

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Prior orthodontic treatment |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heartburn or sour taste in the mouth at night | <input type="checkbox"/> Recent excessive weight gain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> Immune system disorder | <input type="checkbox"/> Swollen, stiff or painful joints |
| <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Injury to: ___Head ___Mouth ___Neck ___Face ___Teeth | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chronic fatigue | | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Congestive heart failure | | <input type="checkbox"/> Wisdom teeth extracted |
| <input type="checkbox"/> Current pregnancy | | <input type="checkbox"/> Other medical history:_____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | _____ |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Irregular heart beat | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw joint surgery | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low blood pressure | _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Memory loss | |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Gastro esophageal Reflux Disease (GERD) | <input type="checkbox"/> Morning dry mouth | |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Muscle spasms or cramps | |
| <input type="checkbox"/> Heart disorder | <input type="checkbox"/> Needing extra pillows to help breath at night | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nighttime sweating | |
| <input type="checkbox"/> Heart beating or pounding irregularly during the night | <input type="checkbox"/> Osteoarthritis | |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Osteoporosis | |
| | <input type="checkbox"/> Poor circulation | |

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, Aredia, or Pamidronate? If so, IV or orally?_____

Family History

1. Have any members of your family (blood kin) had: _____Heart disease
_____High Blood Pressure
_____Diabetes
2. Have any immediate family members been diagnosed or treated for a sleep disorder? _____

Social History

How often do you consume alcohol within 2-3 hours of bedtime?

- Never
- Once a week
- Several days a week
- Daily
-

How often do you consume caffeine within 2-3 hours of bedtime?

- Never
- Once a week
- Several days a week
- Daily

Do you smoke? Yes No How many packs per day? _____

Do you use chewing tobacco? Yes No

Name of primary Physician: _____ Phone: _____

Name of current Dentist: _____ Phone: _____

Last Dental Visit: _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring of 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 the fees for treatment regardless of insurance coverage.

Date: _____

Signature: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to have any photos taken of me to be used for education and training. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

IF YOU HAVE DENTAL INSURANCE, PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

- I will be paying my estimated co-pay at the time of treatment and my credit card number will be kept on file. I hereby authorize 21st Century Dental to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 90 days.**

Cardholder's Name _____

Cardholder's Signature _____

Cardholder's Address (street) _____

Cardholder's Address (city, state and zip code) _____

Cardholder's Telephone # _____

MasterCard Visa AMEX Discover

Credit Card Account # _____

_____/_____
Exp Date

- I will be paying the FULL AMOUNT of my appointment at the time of service by one of the following: CASH, CHECK, CREDIT CARD, or 3rd Party Financing. 21st Century Dental will file my insurance claim on my behalf and will request that the benefits be reimbursed to me.**

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance after insurance pays or over 90 days past due.

Print Name _____

Signature _____

Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PatientName: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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: Kelly Habben

Telephone: 972.255.3712 Fax: 972.255.5693

E-mail: info@21stCenturyDental.com

Address: 4301 N. MacArthur, Suite 100, Irving, TX 75038

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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents 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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____

Date: _____

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****In non "legal" language, this means we can only use your information to file your insurance, provide dental care to you, collect our fee and communicate with other health care providers that we have referred you to.**

21st Century Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{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)
