Chase Dental SleepCare

Phone: (516) 506-0000 | Fax: (516) 822-4260
www.ChaseDentalSleepCare.com | Info@ChaseDentalSleepCare.com

PATIENT INFORMATION

First Name: ____________ Last Name: ____________ MI: ______
Home Phone: ( ) ________ Cell Phone: ( ) ________ Work Phone: ( ) ________
Email Address: ____________
Address: ____________ City: ________ State: ______ Zip: ______
Date of Birth (M/D/Y) ________ Gender: ☐ M ☐ F Social Security Number (SSN): ________
Height: ___Feet ____ Inches ___ Weight (lbs): ____ Martial Status: ☐ Married ☐ Single ☐ Life Partner ☐ Minor
Spouse or Parent/Guardian (if minor) Name: ____________
Emergency Contact: ____________ Relationship: ________ Phone: ( ) ________
REFFERED BY: ____________

EMPLOYER INFORMATION

Employer: ____________ Phone: ( ) ________
Address: ____________ City: ________ State: ______ Zip: ______

HEALTH INSURANCE INFORMATION

Patient's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________
Name of Insured (First, MI, Last): ____________ Insured DOB (M/D/Y): ________
Ins Co.: ____________ Ins ID: ________
Group #: ____________ Plan Name: ________
Business Address: ____________ City: ________ State: ______ Zip: ______
Phone: ( ) ________ Fax: ( ) ________ Email: ________

SECONDARY INSURNACE INFORMATION

DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THIS SECTION
Patient's Relationship to Secondary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________
Name of Insured (First, MI, Last): ____________ Insured DOB (M/D/Y): ________
Ins Co.: ____________ Ins ID: ________
Group #: ____________ Plan Name: ________
Business Address: ____________ City: ________ State: ______ Zip: ______
Phone: ( ) ________ Fax: ( ) ________ Email: ________

MEDICAL CONTACTS

Chase Dental SleepCare™ coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: ____________ Phone: ( ) ________
ENT: ____________ Phone: ( ) ________
SLEEP DOCTOR: ____________ Phone: ( ) ________
DENTIST: ____________ Phone: ( ) ________
OTHER MD: ____________ Phone: ( ) ________

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MEDICAL HISTORY

- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Angina/Chest pain
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Autoimmune disorders
- ☐ Cancer/tumors
- ☐ Chemotherapy
- ☐ High cholesterol
- ☐ Chronic sinus problems
- ☐ Coronary heart disease
- ☐ Pregnant or nursing
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgla
- ☐ Gastroesophageal reflux
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart surgery
- ☐ Heart valve replacement
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Psychiatric care
- ☐ Stomach disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers

SYMPTOMS:

- ☐ Decreased libido
- ☐ Dry mouth
- ☐ Fragmented sleep
- ☐ Hard to initiate or maintain sleep
- ☐ Memory impairment
- ☐ Breathing problems
- ☐ Difficulty concentrating
- ☐ Excessive daytime sleepiness
- ☐ Gasping/choking during sleep
- ☐ Irritability
- ☐ Morning headache
- ☐ Chronic fatigue
- ☐ Disruptive snoring
- ☐ Nocturia

HISTORY OF DISEASE:

Have you ever been diagnosed with a sleep disorder? ☐ YES ☐ NO

How many sleep studies have you had?__________ List dates ______________________________

Which therapies have you tried?

☐ CPAP ☐ Oral Appliance Therapy ☐ Positional Therapy ☐ Surgeries ☐ Over the counter products

Do you have a family history of obstructive sleep apnea? ☐ YES ☐ NO

MEDICATIONS AND SURGERIES: Please list all medical diagnoses and surgeries

____

____

Please List all Allergies ______________________________

____

List any medications you are currently taking and the conditions they are prescribed for

- ☐ GERD ______________________
- ☐ Antibiotics ______________________
- ☐ Anticoagulants ______________________
- ☐ Anxiety/Depression ______________________
- ☐ Anti-Inflammatory Drugs ______________________
- ☐ Barbiturates ______________________
- ☐ Blood Thinners ______________________
- ☐ Diabetes ______________________
- ☐ Heart Medication ______________________
- ☐ High Blood Pressure ______________________
- ☐ Muscle Relaxants ______________________
- ☐ Pain Medication ______________________
- ☐ Sleeping Pills ______________________
- ☐ Other Medication ______________________

Initial: ____________ Date: _____/______/_______

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In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how they would affect you. **Use the following scale to choose the most appropriate number for each situation.**

Situation ✓ *Please tick box*	0 No chance of dozing	1 Slight chance	2 Moderate chance	3 Definitely would doze
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a 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 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	☐	☐	☐	☐

Initial: ____________ Date: _____/______/_______

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CHASE DENTAL SLEEPCARE
Dental solutions for sound sleep.

CPAP NON COMPLIANT FORM

It has been recommended and/or I have attempted to use CPAP (Continuous Positive Airway Pressure) to manage my diagnosed Obstructive Sleep Apnea condition. I find CPAP intolerable to use on a regular basis due to the following reason(s):

____ The mask leaks

____ I am unable to sleep with the CPAP mask and equipment in place

____ I unconsciously remove the CPAP at night

____ The noise from the device disturbs my sleep

____ CPAP does not seem to be effective in reducing/eliminating my symptoms

____ I have tried multiple masks and none are comfortable enough to use

____ I develop sinus/ear/throat/ infections

____ I am claustrophobic

____ My job/ lifestyle prevents nightly use (Army, Reserves, Truck Driver)

____ I would like to try Oral Appliance Therapy as my first line of treatment

____ Other: ____

Because of my intolerance and inability for CPAP to effectively treat my condition, I wish to attempt an altnative therapy. As per the 2006 practice parameters from the American Academy of Sleep Medicine I wish to utilize an oral airway dilator appliance to treat my obstructive sleep apnea.

Print Name: ____

Signature: ____ Date: _____/______/_______

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Informed Consent for the Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by our 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 a person's 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 for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. Oral Appliance Therapy has effectively treated many patients. 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 many still experience symptoms related to your sleep-related breathing disorder.

Side-Effects and Complications of Oral Appliance Therapy
Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, a tight feeling on the teeth, or dry mouth. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.
Follow up visits with your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders
Other accepted treatments for sleep-related breathing disorders include Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below.

Print Name: ____

Signature: ____ Date: _____/______/_______

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing your treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another processional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" means those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions' participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, {we will}{we usually will not} ask you for special written permission. [We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale of information, any use of information for marketing r fundraising purposes, and ____________________________.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:
When a state or federal law mandates that certain health information be reported for a specific purpose;

- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devises;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health and safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of [name of dentist's] Notice of Privacy Practices.

Print Name: ____

Signature: ____ Date: _____/______/_______