RESPIRA
AIRWAY, SNORING & TMJ

Patient Name:_____

Gender:_____ Date of Birth:_____ Marital Status:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Best Contact Phone Number:_____ Ok to text?_____

Email Address:_____

Emergency Contact:_____

Emergency Contact Best Contact Number:_____

Relationship to Patient:_____

GUARANTOR INFORMATION - IF DIFFERENT FROM ABOVE

Name:_____

Relationship to Patient:_____

Address:_____

City:_____ State:_____ Zip Code:_____

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INSURANCE INFORMATION
PRIMARY

Insurance Co Name: _____

Employer of Policy Holder: _____

Name of Policy Holder: _____

Relationship to Patient: _____

Insurance Claim Address: _____

Insurance Claim Phone # _____ Policy Holder Birthdate: _____/ _____/ _____ Sex: _____

Insurance ID # _____ Group # _____ Effective Date: _____

Secondary Insurance Co Name: _____

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insurance and any other health plan to Respira:Airway, Snoring and TMJ . This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges and I authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signed: _____ Date: _____

RESPIRA
AIRWAY, SNORING & TMJ

HIPAA Notice of Privacy Practices

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your Vivos dentist, Vivos office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a durable medical equipment company that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protected health information be disclosed to obtain approval or authorization.

Healthcare Operations: We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may also call you by name in the waiting room when your doctor is ready to see you.

We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative **Name of Personal Representative**

_____ _____

RESPIRA
AIRWAY, SNORING & TMJ

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ Spouse _____
_____ Child(ren)_____
_____ Other_____
_____ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

Messages

Please call: _____ my home
_____ my work
_____ my cell: _____
_____ other: _____

If unable to reach me:

_____ You may leave a detailed message

_____ Please leave a message asking me to return your call

_____ Other _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

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Adult New Patient Registration & Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Chief Complaint: _____

Name of Primary MD_____

SLEEP HISTORY

Lights Out: _____ ❑ AM ❑ PM Lights On: _____ ❑ AM ❑ PM

Number of awakenings during the night: _____ Trips to the bathroom during the night: _____

Do you take any sleep aids to help you sleep? ❑ Yes ❑ No If yes, what kind? _____

_____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do you have a history of any of the following? *(Check if "YES" to any of the following)*

- ❑ Difficulty falling asleep at night
- ❑ Snoring
- ❑ Witnessed apneas
- ❑ Gasping/choking during sleep
- ❑ Sweating/perspiring in sleep
- ❑ Drooling in sleep
- ❑ Dry mouth upon awakening
- ❑ Teeth grinding/clenching Sleep talking
- ❑ Heart palpitations
- ❑ GERD/reflux/heartburn
- ❑ Excessive daytime sleepiness
- ❑ Tired/fatigued during the daytime
- ❑ Nasal allergies/hay fever/nasal congestion
- ❑ Asthma
- ❑ TMJ pain/jaw discomfort
- ❑ Bedwetting
- ❑ Erectile dysfunction
- ❑ Decreased libido
- ❑ Hypertension/high blood pressure
- ❑ Depressed mood/irritability
- ❑ Anxiety/stressed out
- ❑ Difficulty with concentration
- ❑ Memory problems
- ❑ Cold hands/feet
- ❑ Chest pain/chest discomfort
- ❑ Shortness of breath during the day
- ❑ Acting out dreams
- ❑ Morning headaches
- ❑ Difficulty staying asleep
- ❑ Excessive movements in sleep
- ❑ Nightmares/bad dreams
- ❑ Sleep walking

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PAST MEDICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

ALLERGY HISTORY

❑ None Known ❑ YES, to: 1._____ 3._____

2._____ 4._____

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____# of cups of tea per day

_____ # cans or glasses of soda per day _____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol: ❑ None ❑ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

Tobacco: ❑ None ❑ Yes _____ # of packs per day _____ # of years

Recreational Drugs (such as marijuana or cocaine): ❑ None ❑ Yes

If yes, which ones? _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Are you currently pregnant?

Children: ❑ No ❑ Yes How many? _____

Pets: ❑ No ❑ Yes How many? _____ **What type of pet?** _____

Do you have any children or pets that sleep in your bedroom? ❑ No ❑ Yes _____

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FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply and "no" to those that do not apply.):

- ❑ High blood pressure/hypertension
- ❑ Heart disease
- ❑ Stroke
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes
- ❑ Overweight/obesity
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Anxiety
- ❑ Chronic insomnia
- ❑ Restless legs syndrome
- ❑ Multiple sclerosis
- ❑ Sleep walking

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite: Sweats: ❑ Yes ❑ No
Fever: ❑ Yes ❑ No
Fatigue: ❑ Yes ❑ No
Weight Gain: ❑ Yes ❑ No
Weight Loss: ❑ Yes ❑ No

Gastrointestinal:

Heartburn/Indigestion: ❑ Yes ❑ No
Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No
Nausea/Vomiting: ❑ Yes ❑ No
Jaundice: ❑ Yes ❑ No
Abdominal Pain ❑ Yes ❑ No

Allergy/Immunology:

Sneezing: ❑ Yes ❑ No
Runny Nose: ❑ Yes ❑ No
Itchy Eyes or Nose: Hives: ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No
Double Vision: ❑ Yes ❑ No
Vision Loss: ❑ Yes ❑ No

Respiratory:

Cough: ❑ Yes ❑ No
Shortness of Breath: ❑ Yes ❑ No
Wheezing: ❑ Yes ❑ No
Poor Exercise Tolerance: ❑ Yes ❑ No

Genitourinary:

Bed Wetting: ❑ Yes ❑ No
Frequent Urination: ❑ Yes ❑ No
Difficulty Urinating: ❑ Yes ❑ No
Blood in Urine: ❑ Yes ❑ No

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No
Muscle Pain: ❑ Yes ❑ No
Red or Swollen Joints: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No
Sore Throat: ❑ Yes ❑ No
Sinus Congestion: ❑ Yes ❑ No
Hoarseness: ❑ Yes ❑ No

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Cardiac:

Palpitations: ❑ Yes ❑ No
Chest Pain: ❑ Yes ❑ No
Daytime Shortness of Breath: ❑ Yes ❑ No
Nighttime Shortness of Breath: ❑ Yes ❑ No
Ankle Swelling: ❑ Yes ❑ No

Neurologic:

Weakness: ❑ Yes ❑ No
Seizures: ❑ Yes ❑ No
Involuntary Tongue Biting: ❑ Yes ❑ No
Passing Out: ❑ Yes ❑ No
Dizziness: ❑ Yes ❑ No
Headaches: ❑ Yes ❑ No
Numbness: ❑ Yes ❑ No

Skin:

Unusual Moles: ❑ Yes ❑ No
Rash: ❑ Yes ❑ No
Dryness: ❑ Yes ❑ No

Hema/Lymph:

Unexplained Weight Loss: ❑ Yes ❑ No
Unusual Bleeding/Bruising: ❑ Yes ❑ No
Swollen Lymph Nodes: ❑ Yes ❑ No

Endocrine:

Weight Gain: ❑ Yes ❑ No
Heat Intolerance: ❑ Yes ❑ No
Excessive Thirst: ❑ Yes ❑ No
Constipation ❑ Yes ❑ No
Cold Intolerance: ❑ Yes ❑ No

Psych:

Excess Stress: ❑ Yes ❑ No
Memory Loss: ❑ Yes ❑ No
Difficulty with Focus ❑ Yes ❑ No
Trouble Concentrating ❑ Yes ❑ No
Hallucinations: ❑ Yes ❑ No
Nervousness or Anxiety: ❑ Yes ❑ No
Depressed Mood: ❑ Yes ❑ No

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION

RESPIRA
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Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Gender: _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)

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Berlin Questionnaire©
Sleep Apnea

Height _____ Weight _____ Age _____ Gender_____

Please choose the correct response to each question.

Category 1

1. Do you snore?
□ a. Yes
□ b. No
□ c. Don't know

If you answered 'yes':

2. You snoring is:
□ a. Slightly louder than breathing
□ b. As loud as talking
□ c. Louder than talking

3. How often do you snore?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

4. Has your snoring ever bothered other people?
□ a. Yes
□ b. No
□ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ □ e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
□ a. Yes
□ b. No

If you answered 'yes':

9. How often does this occur?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

Category 3

10. Do you have high blood pressure?
□ Yes
□ No
□ Don't know

Scoring Berlin Questionnaire

The questionnaire consists of 3 categories related to the risk of having sleep apnea. Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores in the symptom categories.

Categories and Scoring:
Category 1: items 1, 2, 3, 4, and 5;
Item 1: if '**Yes**', assign **1 point**
Item 2: if '**c**' or '**d**' is the response, assign **1 point**
Item 3: if '**a**' or '**b**' is the response, assign **1 point**
Item 4: if '**a**' is the response, assign **1 point**
Item 5: if '**a**' or '**b**' is the response, assign **2 points**
Add points. *Category 1 is positive if the total score is 2 or more points*.

Category 2: items 6, 7, 8 (item 9 should be noted separately).
Item 6: if '**a**' or '**b**' is the response, assign **1 point**
Item 7: if '**a**' or '**b**' is the response, assign **1 point**
Item 8: if '**a**' is the response, assign **1 point**
Add points. *Category 2 is positive if the total score is 2 or more points.*

Category 3 is positive if the answer to item 10 is '**Yes**' or if the BMI of the patient is greater than 30kg/m_2.
(BMI is defined as weight (kg) divided by height (m) squared, i.e.., kg/m_2).

High Risk: if there are 2 or more categories where the score is positive.

Low Risk: if there is only 1 or no categories where the score is positive.

Additional Question: item 9 should be noted separately.

HIT-6™
(VERSION 1.1)

HEADACHE IMPACT TEST™

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

1 When you have headaches, how often is the pain severe?

Never | Rarely | Sometimes | Very Often | Always

2 How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never | Rarely | Sometimes | Very Often | Always

3 When you have a headache, how often do you wish you could lie down?

Never | Rarely | Sometimes | Very Often | Always

4 In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never | Rarely | Sometimes | Very Often | Always

5 In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never | Rarely | Sometimes | Very Often | Always

6 In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never | Rarely | Sometimes | Very Often | Always

COLUMN 1	+	COLUMN 2	+	COLUMN 3	+	COLUMN 4	+	COLUMN 5
(6 points each)		(8 points each)		(10 points each)		(11 points each)		(13 points each)

To score, add points for answers in each column.

Please share your HIT-6 results with your doctor.

Total Score _____

Higher scores indicate greater impact on your life.

Score range is 36-78.

HEADACHE IMPACT TEST™

What Does Your Score Mean?

If You Scored 60 or More

Your headaches are having a very severe impact on your life. You may be experiencing disabling pain and other symptoms that are more severe than those of other headache sufferers. Don't let your headaches stop you from enjoying the important things in your life, like family, work, school or social activities.

Make an appointment **today** to discuss your HIT-6 results and your headaches with your doctor.

If You Scored 56 – 59

Your headaches are having a substantial impact on your life. As a result you may be experiencing severe pain and other symptoms, causing you to miss some time from family, work, school, or social activities.

Make an appointment **today** to discuss your HIT-6 results and your headaches with your doctor.

If You Scored 50 – 55

Your headaches seem to be having some impact on your life. Your headaches should not make you miss time from family, work, school, or social activities.

Make sure you discuss your HIT-6 results and your headaches at your next appointment with your doctor.

If You Scored 49 or Less

Your headaches seem to be having little to no impact on your life at this time. We encourage you to take HIT-6 monthly to continue to track how your headaches affect your life.

If Your Score on HIT-6 is 50 or Higher

You should share the results with your doctor. Headaches that are disrupting your life could be migraine.

Take HIT-6 with you when you visit your doctor because research shows that when doctors understand exactly how badly headaches affect the lives of their patients, they are much more likely to provide a successful treatment program, which may include medication.

HIT is also available on the Internet at www.headachetest.com.

The Internet version allows you to print out a personal report of your results as well as a special detailed version for your doctor.

Don't forget to take HIT-6 again or try the Internet version to continue to monitor your progress.

About HIT

The Headache Impact Test (HIT) is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36® health assessment tool.

HIT is not intended to offer medical advice regarding medical diagnosis or treatment. You should talk to your healthcare provider for advice specific to your situation.

HIT-6 Scoring Interpretation English Version 1.1

RESPIRA
AIRWAY, SNORING & TMJ

Affidavit for Intolerance or Non-Compliance to CPAP

I, _____, have attempted or do not desire to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis 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 (Fear of tight spaces, anxiety))
- ❑ An unconscious need to remove the CPAP apparatus at night
- ❑ Other (Please be detailed) _____

Because of my intolerance / inability / or medical reason to not use the CPAP, I wish to have my OSA (Obstructive Sleep Apnea) treated by Oral Appliance Therapy utilizing a custom fitted Mandibular or Maxillary Advancement Device.

Signed: _____

Dated: _____