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:_____

RESPIRA
AIRWAY, SNORING & TMJ

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: _____/_____/_____

RESPIRA
AIRWAY, SNORING & TMJ

Kids Intake Form

Date: _____ Your Name: _____

Caller's Name: _____ Relationship: _____

Child's Name: _____ Child's age: _____

How did you hear about us/who referred you to the office? _____

What is happening with your child that prompted you to call?

Does the child have any of these symptoms?

Restless Sleep	☐	Difficulty in School	☐
Nightmares/Night Terrors	☐	Anger/Aggression	☐
Snoring	☐	Irritability	☐
Teeth Grinding	☐	Problems with Speech	☐
Mouth Breathing	☐	Crowded/Crocked Teeth	☐
Bedwetting	☐	Chronic Allergies	☐
Dark Circles Under Eyes	☐	Tonsils/Adenoids	☐
Daytime Drowsiness	☐	Chronic Ear Infections	☐
Trouble Concentrating/Focusing	☐	Delayed Growth	☐
ADD/ADHD	☐	Asthma	☐

Email Address: _____ Phone Number: _____

Date Scheduled for Parent Education Meeting: _____

Emailed parent information packet ☐ Confirmed for Parent Meeting? ☐

Additional Notes On Back ☐

RESPIRA
AIRWAY, SNORING & TMJ

Berlin Questionnaire©
Sleep Apnea

Height: _____ Weight: _____ DOB: _____ 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.

RESPIRA
AIRWAY, SNORING & TMJ

Child New Patient Medical Background Information

PATIENT INFORMATION

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

Parent or Guardian's Name: _____

Chief Complaint or Concern:

_____

_____

_____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Does your child have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Has your child ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

ALLERGY HISTORY

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

2._____ 4._____

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

Do any pets sleep in your child's bedroom? ❑ No ❑ Yes

Which pets? _____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

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

REVIEW OF SYMPTOMS

Constitutional:

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

Respiratory:

Cough:	❑ Yes ❑ No
Asthma:	❑ Yes ❑ No
Wheezing:	❑ Yes ❑ No
Poor Exercise Tolerance:	❑ Yes ❑ No

REVIEW OF SYMPTOMS

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:

Nasal allergies/Hay fever/

Nasal Congestion**:** ❑ Yes ❑ No

Sneezing**:** ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Itchy Eyes or Nose: ❑ Yes ❑ No

Hives: ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss : ❑ Yes ❑ No

Genitourinary:

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

Temporomandibular Joint

(TMJ) pain/jaw discomfort: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

Tubes in Ears: ❑ Yes ❑ No

REVIEW OF SYMPTOMS

Cardiac:

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Hypertension/High Blood Pressure ❑ Yes ❑No

Skin:

Unusual Moles: ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

Endocrine:

Heat Intolerance ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ 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

Psychiatric:

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Was your child breast fed? ❑ Yes ❑ No

If your child was breast fed – for how long? _____

Was your child ❑ Full Term ❑ Premature

If Premature – at how many weeks was your child delivered? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION

RESPIRA
AIRWAY, SNORING & TMJ

Sleep, Breathing, & Habit Questionnaire

Patients Name: _____ Date: _____ DOB: _____

Please indicate if child has these behaviors by using the scale below to indicate the severity of these symptoms.

1 - No occurrence **2 -** Very Rarely **3 -** Occurs 2-4 times a week

4 - Occurs 5-7 times a week **5 -** Occurs daily

Does Your Child:

1. _____ Snore at all

2. _____ Have labored, difficult, loud breathing at night

3. _____ Have interrupted snoring where breathing stops for 4 seconds

4. _____ Have stoppage of breathing more than 2 times in an hour

5. _____ Hyperactive

6. _____ Mouth breathes during day

7. _____ Mouth breathes while sleeping

8. _____ Frequent headaches in morning

9. _____ Allergic symptoms

10. _____ Excessive sweating while asleep

11. _____ Talks in sleep

12. _____ Struggles in Math at School

13. _____ Struggles in Reading at School

14. _____ Wakes up at night

15. _____ Attention deficit

16. _____ Restless sleep

17. _____ Grinds teeth

18. _____ Frequent throat infections

19. _____ Feels sleepy and/or irritable during the day

20. _____ Have a hard time listening and often interrupts

21. _____ Frequent Ear Infections

22. _____ Wet the bed

23. _____ Bluish color at night or during the day

24. _____ Have sensory issues

25. _____ Have avoidance behavior toward food or certain types of food

26. _____ Speech Problems *

**If yes, continue on to speech questionnaire in the section below*

Speech Questionnaire – to be filled out only if #26 was indicated above.

Please check all that apply to you or your child

- ☐ Is it difficult to understand your child's speech?
- ☐ Difficult to understand over the phone?
- ☐ Nasal speech?
- ☐ Hoarseness
- ☐ Speech sounds abnormal?
- ☐ Others have difficulty understanding speech?
- ☐ Sometimes omits consonants
- ☐ Gets frustrated when people can't understand speech?
- ☐ Uses M, N, NG instead of P, F, V, S, Z sounds
- ☐ Swallowing problems with liquids and solids getting into nose?

RESPIRA
AIRWAY, SNORING & TMJ

EPWORTH SLEEPINESS SCALE FOR CHILDREN AND ADOLESCENTS

Name_____DOB_____

Date _____Gender_____

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

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

It is important that you answer each question as best as you can.

Situation	Chance of dozing (out of 3)
Sitting and reading	
Sitting and watching TV or a video	
Sitting in a classroom at school during the morning	
Sitting and riding in a car or bus for about half an hour	
Lying down to rest or nap in the afternoon	
Sitting and talking to someone	
Sitting quietly by yourself after lunch	
Sitting and eating a meal	
Total out of 24	

Score Interpretation: (1-10) Normal Range (10–16) Excessively sleepy (16-24) Abnormally sleepy