# Patient Information

Patient Name: ___________________________________________________________________

Gender: _________________________________ Date of Birth: __________________________

Address: ______________________________________________________________________

City: _________________________ State: ________________ Zip Code: ________________

Best Contact Phone Number: ______________________________ OK to text? ____________

Email Address: _________________________________________________________________

Emergency Contact: _____________________________________________________________

Emergency Contact Phone Number: _______________________________________________

Relationship to Patient: __________________________________________________________

GUARANTOR INFORMATION – IF DIFFERENT FROM ABOVE

Name: ________________________________________________________________________

Relationship to Patient: __________________________________________________________

Address: ______________________________________________________________________

City: _________________________ State: ________________ Zip Code: ________________

## Primary Insurance Information

Insurance Company: ____________________________________________________________

Employer of Policy Holder: _______________________________________________________

Name of Policy Holder: __________________________________________________________

Relationship to Patient: _________________________________________________________

Insurance Claim(s) Address: ______________________________________________________

Insurance Claim Phone Number: ___________________________________________________

Policy Holder DOB: ________________________________ Gender: _______________________

Insurance ID Number: _________________________ Group Number: _____________________

Effective Date: _________________________________________________________________

Secondary Insurance Company Name (optional): ______________________________________

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, TMJ, + Myofunctional Therapy. 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 ***

Printed Name: _________________________________________________________________

Signature: _____________________________________________ Date: ___________________

# 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 PHI 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 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 you PHI as necessary, to a durable medical equipment company that provides care to you. Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or teat 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 you 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 nation 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 guarantor: ______________________________________________________

## Medical Information Release Form

Patient Name: ________________________________________ Date of Birth: _______________

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): ________________________________________________________________
- ☐ Healthcare Provider (Mayo Clinic, Olmsted Medical Center, etc.): ___________________
- ☐ Information is not to be released to anyone

*This release of information will remain in effect until terminated by me in writing.*

**For messages, please call:**

- ☐ My home phone
- ☐ My work phone
- ☐ My cell phone
- ☐ Other (please list): _________________________________________________________

**If unable to reach me:**

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call

The best time to reach me is (day) ____________________ between (time) _________________

Signature: __________________________________________ Date: _______________________

# Children's Intake Form

Date: ________________________________ Your Name: ________________________________

Caller's Name: ________________________ Relationship: _______________________________

Child's Name: ______________________________________ Child's Age: __________________

How did you hear about our office? ___________________________________________________

What signs/symptoms are you noticing with your child that prompted you to call?

Does the child have any of these symptoms?

_____ Restless sleep
_____ Nightmares/night terrors
_____ Snoring
_____ Teeth grinding
_____ Mouth breathing
_____ Bedwetting
_____ Dark circles under eyes
_____ Daytime drowsiness
_____ Trouble concentrating/focusing
_____ ADD/ADHD

_____ Difficulty in school
_____ Anger/aggression
_____ Irritability
_____ Problems with speech
_____ Crowded/crooked teeth
_____ Chronic allergies
_____ Tonsils/adenoids
_____ Chronic ear infections
_____ Delayed growth
_____ Asthma

Email Address: _____________________________________ Phone Number: ________________

Date scheduled for parent education meeting: __________________________________________

Emailed parent information packet: ________ Confirmed for parent meeting? _____________

Additional notes on the back? ____________

RESPIRA

# Berlin Questionnaire©

Height: ____________ Weight: _____________ DOB: _____________ Gender: ____________

Please choose a response that relates to your/your child's symptoms to each question.

## Category 1

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

*If you answered 'yes' above:*

2. Your 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 note 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' above:*

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

## Category 3

10. Do you have high blood pressure?
    a. Yes b. No c. Don't know

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, and 8;

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/m2.*

**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.

## Child NP Medical Background Information

PATIENT INFORMATION

Patient Name: ______________________________________ Date of Birth: ___________________

Parent or Guardian's Name: __________________________________________________________

Chief Complaint or Concern:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

MEDICATIONS

1. _________________________________________ 5. _______________________________

2. _________________________________________ 6. _______________________________

3. _________________________________________ 7. _______________________________

4. _________________________________________ 8. _______________________________

Does your child have any allergies to any medication? ____ Yes ____ No

If yes, please list: ____________________________________________________________________

PAST SURGICAL HISTORY

1. _________________________________________ 5. _______________________________

2. _________________________________________ 6. _______________________________

3. _________________________________________ 7. _______________________________

4. _________________________________________ 8. _______________________________

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

## ALLERGY HISTORY

____ None known ____ Yes, to: ____________________________________________

Pets: ____ No ____ Yes

If yes, how many? _______ What type of pet(s)? _________________________________

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

If yes, which pet(s)? _____________________________________________________

## FAMILY HISTORY

Do you have a family history of any of the following medical illnesses?

___ High blood pressure

___ Heart disease

___ Stroke

___ Congestive heart failure

___ Depression

___ Diabetes

___ Overweight/obesity

___ Snoring

___ Sleep apnea

___ Anxiety

___ Chronic insomnia

___ Restless leg syndrome

___ Multiple sclerosis

___ Sleep walking

## REVIEW OF SYMPTOMS

**Constitutional**:

___ Loss of appetite

___ Fever

___ Fatigue

___ Weight gain

___ Weight loss

**Respiratory**:

___ Cough

___ Asthma

___ Wheezing

___ Poor exercise tolerance

REVIEW OF SYMPTOMS CONTINUED

**Gastrointestinal:**

___ Heartburn/indigestion

___ Black or bloody stools, diarrhea

___ Nausea/vomiting

___ Jaundice

___ Abdominal pain

**Allergy/Immunology:**

___ Nasal allergies/Hay Fever

___ Nasal congestion

___ Sneezing

___ Runny nose

___ Itchy eyes or nose

___ Hives

**Eyes:**

___ Blurry vision

___ Double vision

___ Vision loss

**Genitourinary:**

___ Frequent urination

___ Difficulty Urinating

___ Blood in urine

**Musculoskeletal:**

___ Stiff/sore joints

___ Muscle pain

___ Red or swollen joints

___ (TMJ) pain/jaw discomfort

**Ears/Nose/Throat/Mouth:**

___ Hearing loss

___ Sore throat

___ Sinus congestion

___ Hoarseness

___ Tubes in ears

REVIEW OF SYMPTOMS CONTINUED

Cardiac:

___ Palpitations

___ Chest pain

___ Daytime shortness of breath

___ Nighttime shortness of breath

___ Hypertension/high blood pressure

Skin:

___ Unusual moles

___ Rash

___ Dryness

Endocrine:

___ Heat intolerance

___ Cold intolerance

___ Excessive thirst

___ Constipation

Neurologic:

___ Weakness

___ Seizures

___ Involuntary tongue biting

___ Passing out

___ Dizziness

___ Headaches

___ Numbness

Psychiatric:

___ Excessive stress

___ Memory loss

___ Hallucinations

___ Nervousness or anxiety

___ Depressed mood

Was your child breast fed? ___ Yes ___ No
If your child was breast fed, for how long? _______________________________________________

Was your child ____ full term or ____ premature
If premature, at how many weeks was your child delivered? ________________________________

# Sleep, Breathing, & Habit Questionnaire

Patients Name: _______________________________________ Date of Birth: __________________

*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 per week

**4** – Occurs 5-7 times per 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. ____ Breathing stops more than 2 times in an hour
5. ____ Hyperactive
6. ____ Mouth breathes during day
7. ____ Mouth breathes during night
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. ____ Bedwetting
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.*

## Sleep Questionnaire – to be filled out only if speech problems were indicated above.

*Please check all that apply to you or your child.*

___ Difficult to understand child's speech

___ Difficult to understand over the phone

___ Nasal speech

___ Hoarseness

___ Speech sounds abnormal

___ Other 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

___ Swallowing problems with liquids and solids getting into nose

## Epworth Sleepiness Scale

Name: ______________________________________ Date of Birth: _______________________

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 <u>never</u> doze

1 – <u>Slight</u> chance of dozing

2 – <u>Moderate</u> chance of dozing

3 – <u>High</u> chance of dozing

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

| Situation: | Chance of dozing: |
|---|---|
| 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

# Media Release Consent Form

I, ___________________________________ , agree and give my permission for Respira and their respective doctors to use pictures of __________________________ smile, both before and after, in the capacity of case presentation. I understand that my photos, both before and after, may be used in:

Social media posts (Instagram and Facebook), company website gallery, as well as in-office photography, hanging on the wall in the waiting room, in operatories, and in a compilation book for case presentation.

I understand that these photos will not be used for any other commercial purposes without my written consent.

**By designating the appropriate box below, I grant my permission in the following manner:**

____ I authorize and permit Respira to use my smile photos, full-face photos, first name and a brief story about my smile in all forms of media release as outlined above.

____ I authorize and permit Respira to use my smile photos, full-face photos, and first name but no brief story about my smile in all forms of media release as outlined above.

____ I authorize and permit Respira to use only my smile photos, but not my first name in all forms of media release as outlined above.

Name of patient: __________________________________________

Signature: _______________________________________________ Date: __________________

**Patient, Legal Guardian or Authorized Representative**