RESPIRA

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: _______________

RESPIRA

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: ____

RESPIRA

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: _______________________

RESPIRA

Adult NP Registration & Medical Background Information

PATIENT INFORMATION

Patient Name: ____ Date of Birth: ______________

Chief Complaint(s): ____

Name of Primary Care Provider: ____

SLEEP HISTORY

Lights Out: ____________ AM/PM (circle one)   Lights On: ____________ AM/PM (circle one)

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

Do you take any sleep aids to help you sleep? (circle one) Yes or No

If yes, what kind(s)? ____

MEDICATIONS

1. ____
2. ____
3. ____
4. ____
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________

Do you have a history of 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 awaking
___ Teeth grinding/clenching
___ Heart palpitations
___ GERD/reflux/heartburn
___ Excessive daytime sleepiness
___ Nasal allergies/hay fever/nasal congestion
___ Asthma
___ TMJ Pain/jaw discomfort
___ Bedwetting
___ Erectile dysfunction
___ decreased libido
___ High blood pressure
___ Depressed mood/irritability
___ Anxiety/stressed out
___ Difficulty with concentration
___ Memory problems
___ Cold hands/feet
___ Chest pain/chest discomfort
___ Shortness of breath
___ Morning headaches
___ Difficulty staying asleep
___ Nightmares/bad dreams or sleep walking

RESPIRA

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

SOCIAL HISTORY

Caffeine:
______ # of cups of coffee per day ______ # of cups of tea per day
______ # of cans or glasses of soda per day ______ # of servings of chocolate/week
______ # of energy drinks per day

Alcohol: _____ None _____ Yes → ______ # of drinks per day _____ # of drinks per week

Tobacco: _____ None _____ Yes → ______ # of packs per day _____ # of years

Recreational drugs (marijuana, cocaine, etc): _____ None _____ Yes (please list): ____________

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

Children: ____ None _____ Yes → if yes, how many? _____ Currently pregnant: ________

Pets: ____ None ____ Yes → How many? ______ What type of pet(s)? _________________

Do you have any children or pets that sleep in your bedroom at night? ____ No ____ Yes

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	___ Diabetes	___ Chronic insomnia
___ Heart disease	___ Overweight/obesity	___ Restless leg syndrome
___ Stroke	___ Snoring	___ Multiple sclerosis
___ Congestive heart failure	___ Sleep apnea	___ Sleep walking
___ Depression	___ Anxiety	

REVIEW OF SYMPTOMS

Constitutional:	**Respiratory**:
___ Loss of appetite	___ Cough
___ Fever	___ Asthma
___ Fatigue	___ Wheezing
___ Weight gain	___ Poor exercise tolerance
___ Weight loss	

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

Hema/Lymph:

____ Unexplained weight loss

____ Unusual bleeding/bruising

____ Swollen lymph nodes

Psychiatric:

____ Excessive stress

____ Memory loss

____ Hallucinations

____ Nervousness or anxiety

____ Depressed mood

RESPIRA

Adult Sleep & Breathing Questionnaire

Patient Name: ______________________________________ Date of Birth: _________________

Have you ever had a sleep test administered? ____ No ____ Yes

If yes, when did you have your last sleep test? ____

Have you been diagnosed with sleep apnea? ____ No ____ Yes

Do you currently use a CPAP or sleep appliance for sleep apnea? ____ No ____ Yes

If yes, are you happy with your CPAP or sleep appliance? ____ No ____ Yes

If you are not happy, please tell us 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 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 40cm/15.75inch?	_____	_____
Is your body mass index (BMI) more than 35?	_____	_____

BMI Formula: $\frac{\text{Your weight in pounds x 703}}{\text{Your height in inches x your height in inches}}$

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.

RESPIRA

Epworth Sleepiness Scale

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	____
Watching TV	____
Sitting, inactive in a public place (theatre, meeting, etc.)	____
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 a lunch without alcohol	____
In a car, while stopped for a few minutes in traffic	____
Total out of 24	____

Score Interpretation:

(1-10) Normal range (10–16) Excessively sleepy (16-24) Abnormally sleepy

RESPIRA

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 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 partner's sleep

______ CPAP restricted movements during sleep

______ 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 treated by oral appliance therapy (OAT) utilizing a custom fitted mandibular and/or maxillary advancement device.

Printed Name: ____

Signature: ____

Date: ____

RESPIRA

Media Release Consent Form

I, __________________________________ , agree and give my permission for Respira and their respective doctors to use pictures of my 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

HIT-6™ 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. 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.

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

never — rarely — sometimes — very often — always

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

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

never — rarely — sometimes — very often — always

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

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

never — rarely — sometimes — very often — always

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.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

TOTAL SCORE