**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about our office? Please mark all that apply.**

\_\_\_\_\_\_ Google Search \_\_\_\_\_\_ Radio \_\_\_\_\_\_ Internet Ad \_\_\_\_\_\_ Social Media

Referred by a healthcare professional, family member, or friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

**Adult NP Registration &**

**Medical Background 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following?

\_\_\_ 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

\_\_\_ 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

**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?

\_\_\_ Diabetes

\_\_\_ Overweight/obesity

\_\_\_ Snoring

\_\_\_ Sleep apnea

\_\_\_ Anxiety

\_\_\_ Chronic insomnia

\_\_\_ Restless leg syndrome

\_\_\_ Multiple sclerosis

\_\_\_ Sleep walking

\_\_\_ High blood pressure

\_\_\_ Heart disease

\_\_\_ Stroke

\_\_\_ Congestive heart failure

\_\_\_ Depression

**REVIEW OF SYMPTOMS**

**Respiratory**:

\_\_\_ Cough

\_\_\_ Asthma

\_\_\_ Wheezing

\_\_\_ Poor exercise tolerance

**Constitutional**:

\_\_\_ Loss of appetite

\_\_\_ Fever

\_\_\_ Fatigue

\_\_\_ Weight gain

\_\_\_ Weight loss

**REVIEW OF SYMPTOMS CONTINUED**

**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

**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

**REVIEW OF SYMPTOMS CONTINUED**

**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

**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

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**No**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Yes**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: Your weight in pounds x 703

 Your height in inches x your height in inches

**Berlin Questionnaire©**

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_

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

**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

**Category 1**

1. Do you snore?
	1. Yes
	2. No
	3. Don’t know

*If you answered ‘yes’ above:*

1. Your snoring is:
	1. Slightly louder than breathing
	2. As loud as talking
	3. Louder than talking
2. How often do you snore?
	1. Almost every day
	2. 3-4 times per week
	3. 1-2 times per week
	4. 1-2 times per month
	5. Rarely or never
3. Has your snoring ever bothered other people?
	1. Yes
	2. No
	3. Don’t know
4. Has anyone noticed that you stop breathing during your sleep?
	1. Almost every day
	2. 3-4 times per week
	3. 1-2 times per week
	4. 1-2 times per month
	5. Rarely or never

**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, 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.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Epworth Sleepiness Scale**

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

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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**

 











