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

**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?

\_\_\_\_\_ Difficulty in school

\_\_\_\_\_ Anger/aggression

\_\_\_\_\_ Irritability

\_\_\_\_\_ Problems with speech

\_\_\_\_\_ Crowded/crooked teeth

\_\_\_\_\_ Chronic allergies

\_\_\_\_\_ Tonsils/adenoids

\_\_\_\_\_ Chronic ear infections

\_\_\_\_\_ Delayed growth

\_\_\_\_\_ Asthma

\_\_\_\_\_ Restless sleep

\_\_\_\_\_ Nightmares/night terrors

\_\_\_\_\_ Snoring

\_\_\_\_\_ Teeth grinding

\_\_\_\_\_ Mouth breathing

\_\_\_\_\_ Bedwetting

\_\_\_\_\_ Dark circles under eyes

\_\_\_\_\_ Daytime drowsiness

\_\_\_\_\_ Trouble concentrating/focusing

\_\_\_\_\_ ADD/ADHD

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date scheduled for parent education meeting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emailed parent information packet: \_\_\_\_\_\_\_\_ Confirmed for parent meeting? \_\_\_\_\_\_\_\_\_\_\_\_\_

Additional notes on the back? \_\_\_\_\_\_\_\_\_\_\_\_

**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?
	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

**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

**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.

**PATIENT INFORMATION**

**Child NP Medical Background 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?

\_\_\_ Chronic insomnia

\_\_\_ Restless leg syndrome

\_\_\_ Multiple sclerosis

\_\_\_ Sleep walking

\_\_\_ Diabetes

\_\_\_ Overweight/obesity

\_\_\_ Snoring

\_\_\_ Sleep apnea

\_\_\_ Anxiety

\_\_\_ 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**

**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.*

\_\_\_ 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

\_\_\_ Speech sounds abnormal

\_\_\_ Other have difficulty understanding speech

\_\_\_ Sometimes omits consonants

\_\_\_ Difficult to understand child’s speech

\_\_\_ Difficult to understand over the phone

\_\_\_ Nasal speech

\_\_\_ Hoarseness

**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 **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 you can. \*\*\***

**Chance of dozing:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Situation:**

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**