SAVANNAH DENTAL SPECIALTIES

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

The information you provide in this packet is vital and will assist the doctor during the review of your symptoms. Please respond to all questions. Questions contained within are confidential and will become a part of your healthcare record. Some questions are intended for governmental/statistical purposes only.

PATIENT INFORMATION

Name: _____ **Sex**: F ◯ M ◯
Last First Middle Initial

_____
Home Address City State Zip Code

_____/_____/_____ _____ _____ _____
Date of Birth Height Weight Email Address

Marital Status: Married ◯ Single ◯ Separated ◯ Divorced ◯ Widowed ◯ # of Children ____

Education: _____ **Employment:** _____

Patient Occupation: _____ Business Phone #: _____

PATIENT TELEPHONE NUMBERS

Primary Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯

Alternate Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯

Alternate Number: _____ Home ◯ Work ◯ Mobile ◯ Other ◯

PREFERRED CONTACT: Phone ◯ Text ◯ Email ◯ Other ◯

CONTACT & DISCLOSURE INFORMATION

Please provide contact name in case of an Emergency:

_____ ◯ YES ◯ NO
Name of Individual Relationship to Patient Primary Phone # Leave a Message

Name of individuals to whom all of information about you may be disclosed:

1. _____ ◯ YES ◯ NO
Name of Individual Relationship to Patient Primary Phone # Leave a Message

2. _____ ◯ YES ◯ NO
Name of Individual Relationship to Patient Primary Phone # Leave a Message

If patient is a minor, please provide name of parent/guardian who is responsible for bringing the patient for treatment: _____

Parent/Guardian Name Relationship to Patient Primary Phone #

_____

Street Address City State Zip

PRIMARY / MEDICAL INFORMATION

_____

Primary Insurance Company Subscriber ID Group #

_____

Subscriber's Last Name First Name Relationship to Patient Date of Birth

_____

Secondary Insurance Company Subscriber ID Group #

_____

Subscriber's Last Name First Name Relationship to Patient Date of Birth

HEALTHCARE PROVIDER INFORMATION

Name of primary care Dr. : _____ Phone #: _____
Sleep Dr. : _____ _____Phone #: _____
Dentist: _____ _____Phone #: _____
Other Provider: _____ Phone #: _____

ALLERGIES

*Please indicate any known allergies & select severity of the reaction

□ Aspirin Mild Moderate Severe Reaction: _____
□ Codeine Mild Moderate Severe Reaction: _____
□ Iodine Mild Moderate Severe Reaction: _____
□ Latex Mild Moderate Severe Reaction: _____
□ Melatonin Mild Moderate Severe Reaction: _____
□ Metal Mild Moderate Severe Reaction: _____
□ Peanut Mild Moderate Severe Reaction: _____
□ Penicillin Mild Moderate Severe Reaction: _____
□ Plastic Mild Moderate Severe Reaction: _____
□ Sedatives Mild Moderate Severe Reaction: _____
□ Sleeping Pills Mild Moderate Severe Reaction: _____

□ Please list any other known allergies
□ _____ Mild Moderate Severe Reaction: _____
□ _____ Mild Moderate Severe Reaction: _____
□ _____ Mild Moderate Severe Reaction: _____

□ No known allergies

FAMILY HISTORY

*When selecting a condition, please indicate family relationship to you.

□ Bleeding disorder _____
□ Blood clotting disorder _____
□ Cancer _____
□ Cardiac disorder _____
□ Diabetes _____
□ Heart disease _____
□ High blood pressure _____
□ Obesity _____
□ Obstructive sleep apnea _____
□ Sleep disorder _____
□ Snoring _____
□ Stroke _____
□ Thyroid disorder _____
□ Problems w/ Mood/Mental _____

HABITS

*Please check applicable area(s) below:

Tobacco Use	None □	Rarely □	Moderate □	Daily □	
Alcoholic Beverages	None □	Rarely □	Moderate □	Daily □	
Recreational Drugs	None □	Rarely □	Moderate □	Daily □	
Caffeine Use	None □	Less than 3 cups/day □	3-6 cups/day □	More than 6 cups/day □	
Exercise	None □	Rarely □	Moderate □	Regular □	
Eating Habits	Well □	Regular □	Poor □		
Smoking Status	Current □	Former □			

MEDICAL HISTORY

*Please check applicable condition(s) you have or have had in the past:

☐ Acid Reflux	☐ Depression	☐ Liver disease
☐ Amnesia	☐ Diabetes	☐ Meniere disorder
☐ Anxiety	☐ Emphysema	☐ Multiple sclerosis
☐ Allergy-Nasal	☐ Epilepsy	☐ Neuropathy
☐ Arthritis	☐ Fibromyalgia	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Pregnancy
☐ Atrial fibrillation	☐ GERD	☐ Rheumatic fever
☐ Autoimmune disease	☐ Heart attack	☐ Sinus pain
☐ Bleeding disorder	☐ Hear disease	☐ Sleep apnea
☐ Blood clotting disorder	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ HIV	☐ Tuberculosis
☐ Chronic fatigue syndrome	☐ High blood pressure	☐ Thyroid disease
☐ Congestive heart failure	☐ Low blood pressure	☐ Vascular hear disease
☐ COPD	☐ Insomnia	☐ Vascular dise
☐ Coronary heart disease	☐ Kidney disease	

SOCIAL HISTORY

□ Family stress
□ Financial distress
□ Single □ Married □ Divorced □ Widowed
□ Children □ No children
Do you live alone? □ Yes □ No

□ Employed Occupation: _____
□ Unemployed
□ Retired
Diet □ Healthy □ Normal □ Restricted

SURGICAL HISTORY

□ Adenoidectomy
□ Appendectomy
□ Cholecystectomy
□ Coronary Artery Bypass Graft
□ Hernia Repair
□ Jaw Joint
□ Orthognathic
□ Prior Orthodontic Treatment

□ Sinus Surgery
□ Spinal Surgery, Cervical
□ Spinal Surgery, Lumbar
□ Temporomandibular Joint
□ Tonsillectomy
□ Uvulopalatopharyngoplasty – UPPP
□ Additional Surgeries: _____
□ _____
□_____

CURRENT MEDICATIONS

* If you have a list, a paper copy would be sufficient.

□ Name of medication	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EPWORTH SLEEPINESS SCALE

*Indicate below how likely you are to doze off (or fall asleep) in the following situations.

SITUATION	NEVER	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
As a passenger in a car for 1 hour without a break	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and reading	0	1	2	3
Sitting and talking	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Sitting quietly after lunch with no alcohol	0	1	2	3
Watching television	0	1	2	3

Total: _____

PATIENT CHIEF COMPLAINT

- ☐ CPAP intolerant(Complete Affidavit)
- ☐ Refuse CPAP
  ESS :_____(> 10=EDS)
- ☐ Morning headaches
- ☐ Snoring affecting others
- ☐ Snoring reported
- ☐ Gasping causing wake
- ☐ Fatigue (mild /mold/severe)
  Average hour of sleep per night: _____
  How long does it take you to fall asleep? _____
  Normal bed time: _____
  Sleep aid use:_____
  Naps per day: _____
- ☐ Impaired thinking
- ☐ Insomnia (mild/mod/severe)
- ☐ Dizziness
- ☐ Difficulty Concentrating
- ☐ Witnessed cessation of breathing at night
- ☐ Sleep Apnea (mild/mod/severe)
- ☐ Sleepiness while driving (mild/mod/severe)
- ☐ Forgetfulness
- ☐ TMD (mild/mod/severe)
- ☐ Bruxism: Frequency: _____Mild/Moderate/Severe
- ☐ Jaw Pain: Left/Right or Both
  Freq:_____

ROS/General Symptoms (Please CHECK if significant change in the last 6 months)

- ☐ Health Status (mild/mod/sev)
- ☐ No Dreaming
- ☐ Weight Change
- ☐ Fever
- ☐ Chills
- ☐ Weakness
- ☐ Night sweats
- ☐ Change in appetite
- ☐ Recent trauma
- ☐ Recent infection
- ☐ Recent dental procedure
- ☐ Cold sensitivity
- ☐ Heat sensitivity
- ☐ Tires easily
- ☐ Hearing problem
- ☐ History of sinus infections
- ☐ Sinus Congestion
- ☐ Sore Throat
- ☐ Ringing in ears
- ☐ Gum pain
- ☐ Difficulty swallowing
- ☐ Bruxism/teeth grinding
- ☐ Dry mouth
- ☐ Rash
- ☐ Skin Changes
- ☐ Shortness Breath
- ☐ Difficulty breathing (Day)
- ☐ Chest pain
- ☐ Pressure in chest
- ☐ Hypertension
- ☐ Abdominal pain
- ☐ Vomiting and/or Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Reflux
- ☐ GERD
- ☐ Urinary Frequency
- ☐ Urinary Urgency
- ☐ Incontinence
- ☐ Freq. night urination
- ☐ Sexual Dysfunction
- ☐ TMJ issues
- ☐ Facial edema
- ☐ Headaches
- ☐ Dizziness
- ☐ Difficulty concentrating
- ☐ Bleeding tendency
- ☐ Bleeding gums
- ☐ Depression
- ☐ Change in mood
- ☐ Anxiety
- ☐ Posttraumatic symptoms
- ☐ Psychiatric disorder other than mood:_____
- ☐ Excessive body movement while sleeping
- ☐ Restless legs at night
- ☐ Abnormal blood glucose
- ☐ Diabetes
- ☐ _____
- ☐ _____

Limited to the practice of Dental Sleep Medicine & Orthodontics

Douglas E. Smith, DDS, D.ABDSM, D.ACSDD

CPAP INTOLERANCE/NON-COMPLIANCE AFFIDAVIT

It has been recommended and/or I have attempted to use CPAP (Continuous Positive Air Pressure) to manager my diagnosed Obstructive Sleep Apnea condition. I tried to use CPAP from _____ to _____ or approximately_____months/years.

I find CPAP intolerable to use on a regular basis due to:

_____Mask Leaks

_____Unable to sleep with CPAP mask and hose in place

_____I unconsciously remove CPAP at night

_____The noise from the machine disturbs my sleep

_____CPAP does not seem to be effective in reducing/eliminating my symptoms

_____I have tried multiple masks and none are comfortable enough to use

_____I develop sinus/ear/throat infections

_____I am claustrophobic

_____My job/lifestyle prevent nightly use (i.e., Military, Truck Driver, airline flights overnight)

_____Other:_____

Because of my intolerance and inability to use CPAP effectively to treat my condition, I wish to attempt an alternative therapy. I understand that the American Academy of Sleep Medicine Clinical Practice Guidelines for the treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance Therapy recommends oral appliances rather than no therapy when it is prescribed by a sleep physician and the appliance is made by a QUALIFIED dentist. Dr. Smith is a Board Certified dental sleep medicine specialist who follows AASM guidelines by performing follow-up sleep testing to confirm treatment efficacy.

Patient Name:_____

Patient Signature:_____ Date:_____

Informed Consent for the Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder. A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications. If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below. You will receive a copy.

Signature: _____ Date: _____

Print Name:_____

 x:ADSMConsentForm

Patient Name: _____ Date:_____

Patient Consent Because of HIPPA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By signing below, you permit the release of any information to or from Dr. Smith as required including a full report of examination findings, diagnosis, and treatment program to any y referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Dr. Smith may use your health care information and may disclose such information to your insurance company(ies) and their agents to obtain payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient or Guardian Signature Witness Signature

Consent for Medical Photography:

I consent for medical photographs to be made of me (or my child). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to those medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent, I will contact Dr. Smith's office and place my withdrawal in writing.

By signing this form below, I confirm that this consent form has been explained to me, if requested, in terms which I understand.

1. I consent for photographs to be used in medical publications. I understand that the image may be seen by members of the general public, in addition to scientists that regularly use these publications in their professional education. Although, these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for medical record.

   _____ _____

   Patient or Guardian Signature Witness Signature

2. I agree for my image to be shown for teaching purposes AND to be used for medical record but NOT FOR medical publications.

   _____ _____

   Patient or Guardian Signature Witness Signature

3. I agree to use of my image for medical records ONLY

   _____ _____

   Patient or Guardian Signature Witness Signature

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FINANCIAL POLICY

We participate with many insurance plans, but not all. Keep in mind, it is the responsibility of the member/subscriber to understand coverage and to contact the insurance carrier directly to verify whether a plan covers the services we provide. Since we fabricate oral appliances, which are described by insurance as durable medical equipment, we make every attempt to complete precertification and verify benefits prior to the first appointment. This allows you, the patient, to have a better understanding of costs of treatment and allows us more time to discuss the pros and cons of treatment with you at the first appointment.

As a courtesy, we will file a claim on your behalf. It is the policy of Savannah Dental Specialties to wait 45 days for a response from your carrier. In the event we have not received a response from your carrier within that 60 days, we will refer the balance not paid by the insurance carrier, including any non-covered services and balances applied to your annual deductible, to the attention of the patient/responsible party.

Co-pays, deductibles, and co-insurance payments are due and payable at time of visit. Co-insurance for an oral device for the treatment of sleep apnea, snoring, or TMJ will be set up on a monthly auto-billing payment plan, if needed. You will also be asked to make a payment if your account has an outstanding balance. If you are unable to pay towards your balance or do not have your co-pay amount, you will be asked to reschedule your appointment.

PATIENT RESPONSIBILITY

A statement will be sent to the patient's mailing address and payment is expected upon receipt. When you receive a statement from Savannah Dental Specialties, you are expected to pay the balance upon receipt. If you do not agree with the balance due amount, you should call the phone number on the statement for an explanation of the balance and determining a payment plan, if necessary.

We reserve the right to charge the patient for missed appointments or when cancellations occur with less than 24 hours notice.

If you do not have insurance coverage, payment is expected at the time of service or payment arrangements may be made while you are at our office.

By signing this document, you understand that if a bill has to be turned over to a third-party collection agency for nonpayment, that there will be a collection fee added to my bill of 30%.

_____

Patient Name

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND IOR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT. I GIVE PERMISSION TO SAVANNAH DENTAL SPECIALTIES TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICES DESCRIBED ON EACH MEDICAL CLAIM FORM.

Patient Signature	Date
Witness Signature	Date