Welcome

To Your Dental Sleep Medicine Screening

Please complete the following required paperwork as well as information related to your sleep, general and dental health.

Thank You.

My
Friend's
Dentist

My Friend's Dentist
4622 Oleander Dr. , Wilmington NC 28403

1. Patient Information

General Information

First Name _____ Last Name _____ Middle Initial _____
Preferred Name _____ Date of Birth _____

Address 1 _____Address 2_____
City _____ State_____ Zip_____
Home Phone _____ Work Phone _____ Ext: ____ Mobile Phone_____
Email _____
Preferred Method of Communication ○ Phone ○ Text ○ Email
Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Employment Status ○ Full-time ○ Part-time ○ Retired ○ Unemployed ○ Disabled ○ Student
Current Dentist _____ Last Dental Visit _____
Preferred Pharmacy _____ Pharmacy # (if known) _____
Referred By _____

In Case of Emergency

Emergency Contact Name _____ Emergency Contact # _____
Relationship _____

Insurance Information

Name of Insured _____
Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other
Insured Social Security # _____ Insured Birth Date _____
Home Address (If different from above) _____
City _____ State_____ Zip_____

Employer _____
Insurance Company _____ ID # _____ Group # _____

P.S. We can't wait to find out, how did you hear about us?_____

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2. Medical History

Your oral health is connected to the health of your entire body. It's important for us to know your medical history because health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you receive.

Medical History

Are you under a physician's care now? ○Yes ○ No
If yes, please explain:_____

Have you ever been hospitalized or had a major surgery? ○Yes ○ No
If yes, please explain: _____

Have you ever had a serious head or neck injury? ○Yes ○ No
If yes, please explain_____

Are you taking any medication, pills or drugs? ○Yes ○ No
If yes, please explain and list the medications: _____

_____

Do you take, or have you ever taken, Phen-Fen or Redux? ○Yes ○ No
If yes, please explain: _____

Have you taken Fosamax, Boniva, Actonel or any other Bisphosphonate drugs? ○Yes ○ No
If yes, please explain: _____

Are you on a special diet? ○Yes ○ No
Do you currently smoke? ○Yes ○ No If yes, how many cigarettes on average per day? _____

On average, how much alcohol do you drink per week? _____ beer _____ glasses of wine _____ oz. liquor

On average, how much caffeine do you have each day? ____cups of coffee ____cups of tea ____cans of cola

Women, are you...

○ Pregnant or Trying to Get Pregnant? ○ Taking Oral Contraceptives? ○ Nursing?

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic
○ Metal ○ Latex ○ Sulfa Drugs ○ Local Anesthetics
○ Other If yes _____

Do you use controlled substances? ○Yes ○ No If yes _____

Your height is _____ft. _____ in. Your weight is _____ lbs. ★ OFFICE USE: BMI _____

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Do you have, or have you had, any of the following? Please circle all those that apply.

AIDS/HIV Positive	COPD	Hemophilia	Radiation Treatments
Allergies	Cortisone Medicine	Hepatitis A	Recent Weight Loss
Alzheimer's Disease	Depression	Hepatitis B or C	Renal Dialysis
Anaphylaxis	Diabetes	Herpes	Rheumatic Fever
Anemia	Drug Addiction	High Blood Pressure	Rheumatism
Angina	Easily Winded	High Cholesterol	Scarlet Fever
Anxiety	Emphysema	Hives or Rash	Seizure Disorder
Arthritis/Gout	Epilepsy or Seizures	Hypoglycemia	Sinusitis or Rhinitis
Artificial Heart Valve	Excessive Bleeding	Irregular Heartbeat	Shingles
Artificial Joint	Excessive Thirst	Kidney Problems	Sickle Cell Disease
Asthma	Fainting Spells/ Dizziness	Leg cramps while asleep	Sinus Trouble
Back Problems	Fibromyalgia Syndrome	Leukemia	Spina Bifida
Blood Disease	Frequent Cough	Liver Disease	Stomach/Intestinal Disease
Blood Transfusion	Frequent Diarrhea	Low Blood Pressure	Stroke or CVA
Breathing Problems	Frequent Headaches	Lung Disease	Swelling of Limbs
Bruise Easily	Genital Herpes	Migraine Headaches	Thyroid Disease
Bypass Surgery	GERD	Morning Headaches	Tonsillitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Neurological Disease	Tumors or Growths
Chest Pains	Heart Attack/Failure	Osteoporosis	Ulcers
Chronic Fatigue Syndrome	Heart Murmur	Pain in Jaw Joints	Venereal Disease
Cold Sores/Fever Blisters	Heart Pacemaker	Parathyroid Disease	Visual Disturbance
Congenital Heart Disorder	Heart Troubles/Disease	Post-Nasal Drip	Yellow Jaundice
Convulsions	Heartburn (reflux)	Psychiatric Care	Other

Have you ever had any serious illnesses not listed? ○ Yes ○ No

If yes, please explain _____

To the best of my knowledge, the above medical history questions have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform My Friend's Dentist of any changes in medical status.

Signed _____

Date _____

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4622 Oleander Dr., Wilmington NC

3. Consent

Patient Consent to Treat

1. To the best of my knowledge, all of the proceeding answers and information I have provided are true and correct. If I ever change in my health or insurance coverage; I will inform My Friend's Dentist at the next appointment. I grant My Friend's Dentist permission to provide dental treatment as deemed necessary. I authorize the dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of necessary treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

2. (If signing as the responsible party) I acknowledge that the above information is correct and grant My Friend's Dentist permission to provide my child's dental treatment as deemed necessary. If my child ever has a change in his/her health or his/her medications, I will inform My Friend's Dentist at the next appointment. I will be responsible for the cost of this dental care.

3. I authorize and request the performance of dental services by Dr. Defee and the staff, as designated. I understand that Dr. Defee and the staff will use digital radiographs, diagnostic and patient management techniques that are reasonable, necessary, and advisable. I authorize My Friend's Dentist and their staff to perform my dental care as deemed necessary.

I verify that I have read and understand the above policy.

Signed _____

Date _____

Consent of Transmission of Protected Health Information by Email and Text Message

I consent to transmit the following protected health information related to my health records and health care treatment - Information related to the scheduling of meetings or other appointments, information related to billing and payment, completed forms, including forms that may contain sensitive confidential information, information of clinical nature, including discussion of personal material relevant to my treatment, my health record, in part or in whole, or summaries of material from my health record.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time in writing.

I verify that I have read and understand the above policy.

Signed _____

Date _____

Images Consent

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule.

Please check one:

○ I hereby give permission to My Friend's Dentist to use my intra-oral photographs, x-rays and digital images for the purpose of educational training, our website, or any other lawful purpose. I understand I may change or withdraw this release/consent at any time by contacting My Friend's Dentist.

○ I decline permission to My Friend's Dentist to use my intra-oral photographs, x-rays and digital images for the purpose of educational training, our website, or any other lawful purpose. I understand I may change or withdraw this release/consent at any time by contacting My Friend's Dentist. Your declination will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

I verify that I have read and understand the above policy.

Signed _____

Date _____

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Medical Information Release (HIPAA Release Form)

Full 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) _____
Other _____

This Release of Information will remain in effect until terminated by me in writing.

I verify that I have read and understand the above policy.

Signed _____

Date _____

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My Friend's Dentist
4622 Oleander Dr., Wilmington NC

4. Practice Policies

Receipt of Notice of Privacy Practices
I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that, by signing below, I am authorizing members of My Friend's Dentist and their employees to disclose information about my past and future dental treatment to my insurance company and to other dental professionals and physicians as needed so that I may be provided with the best comprehensive care possible. I also authorize My Friend's Dentist to leave messages regarding appointment times and purpose on an answering machine, voicemail, or with persons answering the phone at the numbers I give them to reach me. I understand that I will be required to sign a release form to give permission for My Friend's Dentist to share information with anyone other than those specified above.

I verify that I have read, understand and agree to the above policies.

Signed _____

Date _____

Financial Policy
We are happy to bill your insurance as a courtesy. However, the patient receiving service (or the responsible party) is ultimately responsible for all fees incurred. We require you to pay the "patient portion" at the time of service, which may include a deductible, co pay, and/or a percentage of each procedure.

If your insurance has not made payment in full within 2 months of treatment, you are responsible for paying the balance, and your insurance company will then reimburse you. We accept cash, checks, VISA, and MasterCard. We also offer financing through Care Credit.

If a check is returned for non-sufficient funds, a returned check fee of $30 will be added to your account. Past due accounts are subject to finance charges. All accounts past 90 days are also subject to small claims court or outside collections.

For patients receiving sedation during their visit, payment is required 48 hours prior to treatment.

I verify that I have read, understand and agree to the above policies.

Signed _____

Date _____

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Appointment Policy

We consider the time set aside for your appointment to be your reserved time. In order to allow all patients experience the best possible appointment arrangement, please recognize the following cancellation policy and fee associated with our practice.

1. Confirmation of your appointment

For appointments scheduled more than 48 hours in advance, a confirmation via text, email, online chat or phone is required prior to your appointment.

2. If you need to cancel an appointment

If you are unable to keep your appointment, please let us know immediately so that we are able to offer your appointment time to another patient. At the discretion of My Friend's Dentist, appointments cancelled less than 48 hours before their scheduled time will be considered a missed appointment and a $50 cancellation fee, not covered by insurance, will be charged.

3. If you're running late for an appointment

We realize that traffic, weather or other unforeseeable circumstances can play a role in being late for an appointment. We accommodate appointments up to 10 minutes late without rescheduling.

4. If you need to miss an appointment

We understand that last minute changes in your schedule or emergencies may arise that cause you to miss your appointment. If you've missed 2 appointments within a calendar year, you will be placed on a waiting list for future appointments and be ineligible to pre-appoint. Missing 3 or more appointments within a calendar year may result in a formal dismissal from our office. This ensures that patients who keep their appointments will be able to occupy timeslots that are available.

I verify that I have read, understand and agree to the above policy.

Signed _____

Date _____

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5. Sleep Questionnaire

Please rate from 1 to 3, in order of importance to you, the top three reasons you are here today:

Problems with sleep _____

Snoring bothering bed-partner _____

Snoring bothering you _____

Daytime sleepiness or fatigue _____

Don't want to wear CPAP _____

Cannot tolerate CPAP _____

Other _____

Sleep History

Have you ever had a sleep study? ○ Yes ○ No

If yes, when was it done? Date _____ Location/Provider _____

Have you tried CPAP? ○ Yes ○ No

Do you use CPAP now? ○ Yes ○ No How long have you used it? _____ years.

Have you tried other treatments? Please describe _____

_____

Do you have non-restorative sleep? Feeling not rested/ refreshed/ restored in the morning in spite of getting adequate amount of sleep) ○ Yes ○ No If yes, how many times per month? _____ /30

Do you have trouble falling asleep? ○ Yes ○ No If yes, how many times per month? _____ /30

Do you have trouble staying asleep? ○ Yes ○ No If yes, how many times per month? _____ /30

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PSG with Patient ○ Yes ○ No	○ Diagnostic ○ Titration
Study Date	AHI
Provider	RDI
CPAP Tried ○ Yes ○ No	H20 CM
SaO2 nadir	
Phase Related ○ Yes ○ No	Positional ○ Yes ○ No

Sleep History (Continued)

For each of the following statements please circle the response that best describes your sleep over the past month.

I have had difficult getting up in the morning:

O Never O Rarely O Sometimes O Often

I wake up feeling rested:

O Never O Rarely O Sometimes O Often

I have felt as if I have not slept long enough, even after having enough time in bed:

O Never O Rarely O Sometimes O Often

I feel refreshed after sleep:

O Never O Rarely O Sometimes O Often

What time is your usual bedtime? _____

What time do you usually get up? _____

How many times per night do you get out of bed? _____

How many times per night do you need to use the bathroom? _____

Please check all that apply. Please try to be thorough and complete in order to help provide a clear picture of your sleep history. Check the box if this describes half the time or more .

O You have trouble falling asleep	O You sleep alone
O You waken often at night	O You sleep with a bed partner
O You have trouble falling back to sleep	O You awaken with a dry throat
O You nap	O You have headaches on awakening
O You prefer to sleep on your back	O You drool while sleeping
O You prefer to sleep on your side	O You have ever awakened choking
O You prefer to sleep on your stomach	O You have ever awakened gasping
O You do not have a regular bedtime	O You have acid reflux at night only
O You use the bathroom more than once a night	O You have family members who have apnea
O You use medications to help you sleep	O You have had adult orthodontics
O Your nose is stuffy going to bed	O You have a history of grinding or clenching
O You have a history of jaw pain	O You have a history of gum disease
O You work shifts	O You sometimes get swollen ankles

Epworth Sleepiness Scale

Please rate how likely you would be to doze off or fall asleep in the following situations in contrast to just feeling tired. Even if you have not done some of these things recently, try to estimate out how they would have affected you.

Activity	Score
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theatre or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after lunch (served with no alcohol)	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Total _____

Berlin Questionnaire

Category 1

1. Do you Snore?
O Yes
O No
O Don't Know

2. Your Snoring is…
O Slightly louder than breathing
O As loud as talking
O Louder than talking
O Very loud – can be heard in adjacent rooms

3. How Often Do You Snore?
O Nearly every day
O 3-4 times per week
O 1-2 times per week
O 1-2 times per month
O Never or nearly never

4. Has your snoring ever bothered other people?
O Yes
O No
O Don't Know

5. Has anyone ever noticed that you quit breathing during your sleep?
O Nearly every day
O 3-4 times per week
O 1-2 times per week
O 1-2 times per month
O Never or nearly never

★ OFFICE USE: _____

Category 2

6. Do often do you feel tired or fatigued after your sleep?
O Nearly every day
O 3-4 times per week
O 1-2 times per week
O 1-2 times per month
O Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?
O Nearly every day
O 3-4 times per week
O 1-2 times per week
O 1-2 times per month
O Never or nearly never

8. Have you ever nodded off while driving?
O Yes
O No

9. If yes, how often does this occur?
O Nearly every day
O 3-4 times per week
O 1-2 times per week
O 1-2 times per month
O Never or nearly never

★ OFFICE USE: _____

Category 3

10. Do you have high blood pressure?
O Yes
O No
O Don't know

★ OFFICE USE
BP: _____

BMI > 30
O Yes
O No

★ OFFICE USE: _____

★ OFFICE USE **BERLIN TOTAL** _____

Stop Bang

Do you snore?	O Yes O No
Do you feel tired, fatigued or sleepy during the day?	O Yes O No
Has anyone observed you stop breathing in your sleep?	O Yes O No
Do you have high blood pressure?	O Yes O No

★ OFFICE USE **STOP TOTAL** _____

★ OFFICE USE: Neck Size cm BMI

----------★ OFFICE USE ----------

B	A	N	G
BMI	AGE	Neck Size	Gender
>35	>50yr	>40cm > 15.7"	=Male

★ OFFICE USE **STOP BANG TOTAL** _____

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Adjusted Neck Circumference

Neck circumference in cm.	_____ cm
History of hypertension	O Yes O No +4
Habitual snoring	O Yes O No +3
Witnessed apneas	O Yes O No +3

< 43 = low probability of OSA

43 – 48 = intermediate probability of OSA

>48 = high probability of OSA

★ OFFICE USE **ANC TOTAL** _____

Review & Signature

By signing this document I certify that I have provided accurate answers to the above questions to the best of my ability. I understand that providing inaccurate answers may be dangerous to my health and result in inappropriate treatment. I authorize Dr. Farquhar to perform diagnostic procedures as may be required to provide necessary treatment. I understand that information provided from, or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the services for myself is mine, and I assume responsibility for fees associated with these services.

Signature _____ Date _____

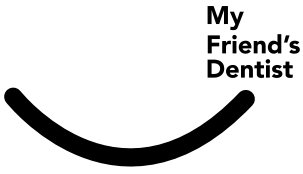
Reviewed by Treating Dentist _____ Date _____

★ OFFICE USE

	Score
AHI	
BMI	
Epworth	
Berlin	
STOP BANG	
ANC	

All finished!

Thank you and welcome to the practice.



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----------★ OFFICE USE ONLY ★ ----------

Date _____

Assessment:

_____

_____

_____

_____

Plan:

_____

_____

_____

_____

Letters:

_____

_____

_____

_____

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, 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**	Categories 2: items 6, 7, 8 (item 9 should be noted separately). • 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** **Category 2 is positive if total score is 2 or more** **Category 3 is positive if the answer to item 10 is 'Yes' OR if BMI > 30** • **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

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