Sleep Apnea Dental Solutions
Michael R. Thompson, DDS, PC
7102 E. Acoma Dr., Ste #3 * Scottsdale, AZ 85254 * (480) 556-0310

PATIENT INFORMATION

Name:_____ Birthdate:_____ _____SS#:_____

Address:_____ _____City:_____ State: _____ Zip:_____

Sex: ___M ___F ___ Married ___Widowed ___ Child ___ Single ___Divorced

E-mail: _____ Home Phone: _____

Cell Phone: _____**Is it Ok to contact you regarding appointments by: Email? Y / N Text? Y / N**

Employer/School: _____Employer/School Phone: _____

Employer/School Address:_____City: _____ State: _____ Zip _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____Phone: _____

Responsible Party (If different from info above)

Name of Person
Responsible for this Account:_____Relation to Patient:_____

Address: _____ Phone: _____

Birthdate:_____

Employer: _____ Work Phone: _____

Is he/she currently a patient in our office? _____ Yes __ No E-Mail: _____

Primary Medical Insurance Information

Name of Policy Holder:_____ Relation to Patient: _____

Birthdate:_____ Social Security #: _____Date Employed: _____

Employer: _____ Work Phone: _____

Employer Address: _____City: _____State: _____Zip: _____

Insurance Company: _____Insurance Phone: _____

Address: _____City: _____ State: ____ Zip: _____

Insurance ID#: _____Group #_____

Secondary Insurance

Name of Insured: _____ Relation to Patient: _____

Birthdate:_____ Social Security #: _____Date Employed: _____

Employer: _____ Work Phone: _____

Employer Address: _____City: _____State: _____Zip: _____

Insurance Company: _____Insurance Phone: _____

Address: _____City: _____ State: ____ Zip: _____

Insurance ID#: _____Group #_____

Patient Name: _____

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MEDICAL HISTORY:

Physician's (PCP) Name: _____ **Date of last visit:** _____

1. **Have you taken any BISPHOSPHONATE drugs? Alendronate (Fosamax), Zoledronate (Zometa), Pamidronate (Aredia), Risedronate (Actonel), Clondronate, Ibandronate, Etidronate (Didronel) ?** _____ **Yes** _____ **No**

2. **Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.** _____**Yes** _____**No**

3. **Have you been under the care of a medical doctor during the past two years?** ____**Yes** ____ **No**
   If yes, for what?_____

   Physician's Name: _____**Phone #:** _____

4. **Have you had any serious illnesses or operations, or hospitalized?** _____ **Yes** _____**No** **If yes, describe** _____

5. **Have you ever had a blood transfusion?** ____**Yes** ____**No** **if yes, give approximate dates** _____

   Height_____ **Current Weight** _____ **Weight 5 yrs**_____ **Peak Lifetime Weight** _____ **Neck Circumference** _____

6. **Are you aware of having an allergic or adverse reaction to any medication or substance?** _____**YES** ____**NO**
   If yes, please list: _____

7. Please circle which of the following you have had, or have at present:

Anemia	Cough up Blood	High Blood Pressure	Shortness of Breath
Arthritis, Rheumatism	Cough, Persistent	HIV/AIDS	Skin Rash
Artificial Heart Valves	Diabetes	Jaw Pain	Snoring/Sleep Apnea
Artificial Joints, Pins, etc	Epilepsy	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Surgical Implant
Back Problems	Glaucoma	Mitral Valve Prolapse	Swelling of Feet or Ankles
Bleeding Abnormally	Headaches	Multiple Myeloma	Thyroid Problems
Cancer	Heart Murmur	Osteoporosis	Tobacco Habit
Chemical Dependency	Heart Problems	Pacemaker	Tonsillitis
Chemotherapy	Hemophilia	Radiation Treatment	Tuberculosis
Circulatory Problems	Hepatitis Type: A B C	Respiratory Disease	Ulcer
Congenital Heart Lesions	Hernia Repair	Scarlet Fever	Venereal Disease
Cortisone Treatments	Depression		

ANY DISEASE, CONDITION OR PROBLEM NOT LISTED: _____

NONE OF THE ABOVE.

8. Ear, Nose and Throat ~ Please check which of the following you have had, or have at present:

☐ A sore throat that does not heal	☐ A white or red patch in your mouth	☐ Pain on chewing or opening your mouth
☐ Difficulty in swallowing	☐ Persistent hoarseness	☐ Persistent pain in the ear
☐ Loss of smell, a bloody nasal	☐ A lump or mass in the neck	☐ Persistent bad breath
☐ discharge, or	that does not heal	☐ Persistent nasal congestion
coughing up blood	☐ Nasal Allergies	☐ Reflux Symptoms

9. Dental History

Current Dentist: _____Phone # : _____

Date of last dental care _____Date of last dental X-rays:_____Date of last dental cleaning: _____

Planned Dental Treatment? _____

Tonsillectomy: ___Yes ___No **Nasal Septal Deviation**: ___Yes ___No **Wisdom Teeth out**: ____Yes ___ No **Ortho Tx**:___Yes ___No

Do you have dental implants? ___Yes ___No **Do you have a denture or partial denture?** ___ Yes ___ No

If yes which one?_____

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Current Medications	Reason For Taking	Prescribing Physician

History Review:

Doctor's Signature: _____ **Date:** _____

CONSENT:

___ **(Initials)** To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. The undersigned hereby authorizes Dr Michael R Thompson to take necessary radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr Thompson to make a thorough diagnosis of the patient's dental needs. I authorize Dr Thompson to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient): _____, and further authorize and consent that Dr Thompson choose and employ such assistance as he deems fit. I further understand that the use of anesthetic agents embodies a certain risk.

Authorization and Release

___ **(Initials)** I certify that I, and/or my dependent(s), have insurance coverage with (insurance company) _____ assign directly to **Michael R. Thompson, DDS, PC** all insurance benefits, if any, otherwise payable to me for services rendered I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. *I understand that responsibility for payment for services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered, whether or not paid all or in part by my insurance plan.* I understand that it is my responsibility to inform Michael R. Thompson, D.D.S of any changes in my insurance carrier and/or coverage. I understand that I will be responsible for payment in full if my insurance company takes longer than 60-days from the date of service to process my claims when claims have been submitted timely by this office. Any changes that are acquired as a result of not informing Michael R. Thompson, D.D.S of insurance carrier changes are my financial responsibility and must be paid within 60 days of the date of service.

___ **(Initials)** I further understand that a 1 ½ % finance charge (18% annually) will be added to *any* balance *over 60 days; including pending insurance claims*. In the event of default, I (We) promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

Relationship to Patient: _____

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Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ **Your sex**: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below,
in contrast to feeling just tired?
This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently try to work out 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

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
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 the traffic	
Total	

Score Results :
1-6 - Normal Range
7-8 - Borderline
9 and up – Should seek medical advice.

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Affidavit of Intolerance to CPAP

PATIENT NAME: _____
DATE CPAP WAS TRIED: _____

I have attempted to use nasal CPAP to manage my sleep disordered breathing (obstructive sleep apnea) and find it intolerable to use on a regular basis due to the following reasons:

- ☐ I am unable to sleep with CPAP equipment in place.
- ☐ The noise from the device disturbs my sleep or my bed partner's sleep.
- ☐ I cannot find a comfortable mask.
- ☐ The mask leaks.
- ☐ I develop sinus / throat / ear / lung infections.
- ☐ I am allergic to materials in the mask and head straps.
- ☐ Claustrophobia
- ☐ I unconsciously remove the CPA apparatus at night.
- ☐ The pressure of the mask and straps cause tissue breakdown.
- ☐ My job and/or lifestyle prevent this form of therapy (e.g. Active Army / National Guard Duty)
- ☐ Prior throat surgery made CPAP intolerable.
- ☐ Refused to attempt CPAP usage.
- ☐ CPAP was ineffective in controlling my symptoms
- ☐ OTHER: _____
- ☐ _____

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of OSA, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

SIGNATURE: _____ **DATE:**_____

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Patient History:

Yes No Do you have your last meal of the day within two hours of bedtime?
Yes No Do you have a problem with heartburn (GERD) on a regular basis?
Yes No Do you smoke tobacco?
If yes, how much per day?_____ How long have you smoked?_____
Yes No If you smoke tobacco do you smile when you wake up during the night?
Yes No If you smoke tobacco, have you noticed that nicotine alters or interferes with your sleep?
Yes No Do you usually drink coffee, tea, chocolate, cola, or other caffeinated beverages within 3 hours of your bedtime?
How much of the following do you drink in a usual day?
Coffee/ Tea _____ Cola _____ Chocolate _____ Other _____
Yes No Do you drink alcoholic beverages?
Assuming the following drinks are equivalent to 12 oz. beer / 5 oz. wine / 3 oz. hard liquor- then:
How many drinks do you have in a usual week day? _____ Weekend or Holiday? _____
Yes No Do you drink alcohol within two hours of bedtime?
Yes No Do alcoholic beverages alter or interfere with your sleep?
Yes No Have you ever used alcohol in order to go to sleep?
Yes No Have you ever sought treatment/ counseling for an alcohol problem?

How long does it typically take for you to fall asleep? ☐ 5-15 min. ☐ 15-30 min. ☐ Longer than 30 min.
Yes No Have you ever needed to take medication to assist in sleep?
If so, which medications? _____
Yes No Do you snore?
Yes No Has anyone witnessed apneas during your sleep?
Yes No Have you woken in severe sweats?
Yes No Do you frequently cough during your sleep?
Yes No Have you ever woken gasping and or choking?
Yes No Do you wake with a dry mouth?
Yes No Have you ever been told you grind or clench your teeth during sleep?
Yes No Do you commonly wake from sleep to use the restroom?
If yes how many times per night? ☐ 1-2 times ☐ 3-4 times ☐ more than 4 times per night
Yes No Do you wake up refreshed
Yes No Do you have headaches in the morning?
Yes No Do you have daytime sleepiness?
Yes No Have you ever been sleepy while driving?
Yes No Do you take naps during the day?
If so, how many times per day? ☐ Once a day ☐ Twice a day ☐ 3 or more times in a day
How long do your naps last? _____
Yes No Do you exercise?
If so, how often do you exercise?_____

Family History:

Yes No Has your mother or father had a history of snoring? ☐ Mother ☐ Father
Yes No Has your mother or father been diagnosed with Sleep Apnea? ☐ Mother ☐ Father

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Authorization for Release of Medical Information

I _____(Patient's Name)

_____(Patient's Address)

_____

Herby authorize:

_____(Physician's Name)

_____(Physician's Address)

_____

To release any information in my medical records relating to my diagnosis and treatment history for sleep disorders and sleep disordered breathing to our office to assist in the evaluation of my suitability for treatment of sleep disordered breathing.

Dr. Michael Thompson
7102 E. Acoma Dr. Suite 3
Scottsdale, AZ 85254
Phone: 480-556-0310
Fax: 480-556-0340
Info@kierlanddentalcenter.com

I authorize the release of a full report of examination findings, diagnosis, treatment problem, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

Patient's Signature: _____ **Date:**_____

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Receipt of Privacy Policies and Practices:
I have received and copy of Michael R. Thompson, D.D.S., PC's Privacy Policies and Practices and reviewed them prior to giving consent for release of information and treatment. I understand that I may request in writing to restrict how my private information is disclosed to carry out treatment or for payment by a third-party payer.

Consent for Release of Information:

I understand that, under the Health Insurance Portability & Privacy Act of 1996 (HIPPA), that I have certain rights to privacy in regards to my protected health information. I authorize Michael R. Thompson, D.D.S, PC to release this information to: conduct normal healthcare operations, obtain payment from third-party payers, and plan my treatment and follow up with our healthcare providers.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Patient's Name and Date of Birth **Date**

Legal Representative Information (if applicable):

Name:_____ Relationship:_____

Address:_____
Street City State Zip

I, _____, give my consent and authorization for Michael R. Thompson, DDS and his staff to discuss and disclose any personal health information regarding my dental treatment and financial matters related to dental treatment to the following person(s):

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Patient Signature: _____ **Date:** _____

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information (PHI), and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, email and/or text, or letters).

Email: We may use or disclose your health information for purposes of appointments, treatment, coordination of care, and/or electronic copies of your patient records via encrypted and unencrypted E-mail systems to you, or treating specialists. There is some level of risk that third parties might be able to read unencrypted emails. We have an option for you to open a Secure Portal within our HIPAA compliant appointment reminder software/vendor at your request.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in

the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. *You must make the request in writing.* You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official.If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full. I can withdraw my consent to electronic communications by calling the office.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Michael R Thompson, DDS, PC **Telephone:** (480) 556-0310 **FAX:** (480) 556-0340
Address: 7102 E Acoma Dr; Ste #3; Scottsdale, Arizona 85254 **E-mail:** info@kierlanddentalcenter.com