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# Snore & Sleep Apnea Center

Today's Date:_____

☐ MR. ☐ MS. ☐ MRS. ☐ DR. NAME:_____
FIRST MIDDLE INITIAL LAST

AGE:_____DOB:_____ ☐ MALE ☐ FEMALE

ADDRESS: _____

CITY, STATE, ZIP:_____

EMPLOYED BY:_____

ADDRESS:_____

SSN:_____HOME PHONE:_____WORK PHONE:_____

CELL PHONE:_____EMAIL:_____

REFERRED BY:_____

GENERAL DENTIST (DDS):_____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE LAST YEAR:_____

_____

INSURANCE COMPANY:_____

GROUP #_____PLAN #_____

RESPONSIBLE PARTY:_____

Patient Signature:_____ Date:_____

web GillespieDentistry.com
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Vancouver, WA 98683

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# Medical History

HEIGHT:_____FT_____INCHES WEIGHT:_____POUNDS

Y ☐ N ☐ Anemia
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disease
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Chronic sinus problems
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Heartburn, GERD
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Irregular heartbeat
Y ☐ N ☐ Congestive heart failure
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Difficulty concentrating
Y ☐ N ☐ Dizziness
Y ☐ N ☐ High blood pressure
Y ☐ N ☐ Migraines
Y ☐ N ☐ Morning dry mouth
Y ☐ N ☐ Muscle spasms
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Fibromyalgia
Y ☐ N ☐ Frequent sore throats
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Need extra pillows to help breathe at night
Y ☐ N ☐ Nighttime sweating
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Heart disease
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Recent excessive weight loss
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Swollen, stiff, or painful joints
Y ☐ N ☐ Tonsillectomy
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Thyroid problems

Have genetic members of your family had:

**Yes/No**

Y ☐ N ☐ Heart disease?
Y ☐ N ☐ High blood pressure?
Y ☐ N ☐ Diabetes?

OTHER MEDICAL HISTORY: _____

ALLERGENS:_____

MEDICATIONS:_____

Patient Signature:_____ Date:_____

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# Medical History Cont.

How often do you consume alcohol within 2–3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never

How often do you take a sedative within 2–3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never

How often do you consume caffeine within 2–3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never

Do you smoke? Y ☐ N ☐ If YES, how many packs per day?

Do you use chewing tobacco? Y ☐ N ☐ If YES, how many times per day?

# Dental History

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Yes/No**

Y ☐ N ☐ Have you ever had teeth extracted? If YES, please describe:_____

_____

Y ☐ N ☐ Do you wear removable dentures?

Y ☐ N ☐ Do you wear full dentures?

Y ☐ N ☐ Have you ever worn braces (orthodontics)? If YES, date completed:_____

Y ☐ N ☐ Does your TMJ (jaw joint) click or pop?

Y ☐ N ☐ Do you have pain in this joint?

Y ☐ N ☐ Have you ever had gum problems?

Y ☐ N ☐ Do you have dry mouth?

Y ☐ N ☐ Have you ever had an injury to your head, neck, or mouth?

Y ☐ N ☐ Are you planning to have dental work done in the near future?

Y ☐ N ☐ Do you clench or grind your teeth?

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# Sleep

**What are your main concerns?**

- ☐ Frequent snoring
- ☐ Excessive daytime sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping/choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

Other: _____

**Epworth Sleepiness Scale**

____Sitting and reading
____Watching TV
____Sitting inactive in public place (theater)
____As a car passenger for an hour without a break
____Lying down in the afternoon to rest
____Sitting and talking to someone
____Sitting quietly after lunch without alcohol
____ In a car while stopped at a traffic light

0 = No chance of dozing
1 = Slight change of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

**Total** = _____

Patient Signature:_____ Date:_____

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# Sleep Cont.

**Subjective signs and symptoms**

Rate your overall energy level (Low) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (Excellent)

Rate your sleep quality (Low) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (Excellent)

Have you been told you snore? ☐Y ☐N

Rate the sound of your snoring (Quiet) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (Loud)

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches? _____

Do you have a bed partner? ☐Y ☐N ☐Sometimes

Do you sleep in the same room? ☐Y ☐N

How many times per night does your bedtime partner notice you stop breathing?

☐Several times per night ☐Once per night ☐Several times per week ☐Occasionally/seldom ☐Never

Have you ever had a sleep study? ☐Y ☐N If YES, where and when?

_____

Have you tried a CPAP? ☐Y ☐N

Are you currently using a CPAP? ☐Y ☐N

If YES, how many nights per week do you wear it?_____/7 nights

When you wear your CPAP, how many hours per night do you wear it?_____hours per night

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## Informed Consent for the Treatment of Sleep-Related Breathing Disorders with Oral Appliance Therapy

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 (OAT) 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.

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## Informed Consent (Continued)

**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. The risks and benefits of these alternative treatments should be discussed with your healthcare provider.

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, and consent to performance of oral appliance therapy, please sign and date this form below. You will receive a copy.

Patient Signature:_____ Date:_____

Print Name: _____

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## Authorization for Release of Medical Information

I,_____(Patient's name)

_____ (Patient's address)

_____

_____, (Patient's date of birth)

hereby 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

Dennis H. Gillespie, DDS
13200 SE McGillivray Blvd
Vancouver, WA 98683
Telephone: 360.892.6132
Fax: 360.892.0297

to assist in the evaluation of my suitability for treatment of sleep-disordered breathing.

I authorize the release of a full report of examination findings, diagnosis, treatment program, 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.

Print name: _____

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**Consent for Release of Information**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy in regard to my protected health information. I authorize Dennis H. Gillespie, DDS, to release this information to conduct normal healthcare operations, obtain payment from third-party payers, and plan my treatment and follow-up with other healthcare providers.

**Change of Insurance Carrier(s) and/or Coverage**

I understand that it is my responsibility to inform Dennis H. Gillespie, DDS, of any changes in my insurance carrier and/or coverage. Any charges that are acquired as a result of not informing Dennis H. Gillespie, DDS, of these changes are my financial responsibility and must be paid within 60 days of the date of service.

**Receipt of Privacy Policies and Practices**

I have received a copy of the Privacy Policies and Practices of Dennis H. Gillespie, DDS, 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.

_____ _____

Signature of patient or legal representative Date

_____ _____

Patient's name Date of Birth

Legal Representative Information:

Name: _____ Relationship: _____

Address: _____

Street City State ZIP code

Phone: _____

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## Affidavit of Intolerance to or Noncompliance with CPAP

I, _____, have attempted to use CPAP (continuous positive air pressure) to manage my sleep-related breathing disorder, OSA (obstructive sleep apnea), and find it intolerable to use on a regular basis for the following reason(s):

- ☐ An inability to get the mask to fit properly
- ☐ Disturbed or interrupted sleep due to the presence of the device
- ☐ Noise level from the device disturbing sleep or bed partner's sleep
- ☐ CPAP restricts movements during sleep
- ☐ Mask/nasal accessory leaking beyond comfort
- ☐ Discomfort caused by the straps and headgear
- ☐ Pressure on the upper lip causes tooth-related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ Other

Due to my intolerance of/inability to use the CPAP, I wish to have my OSA treated by oral appliance therapy using a custom-fitted mandibular-advancement device.

Signed: _____

Dated: _____

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