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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:_____

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

_____

INSURANCE COMPANY:_____

GROUP #_____PLAN #_____

RESPONSIBLE PARTY:_____

Patient Signature:_____Date:_____

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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 partials?

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?

Patient Signature:_____Date:_____

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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) O1 O2 O3 O4 O5 O6 O7 O8 O9 O10 (Excellent)

Rate your sleep quality (Low) O1 O2 O3 O4 O5 O6 O7 O8 O9 O10 (Excellent)

Have you been told you snore? ☐

Rate the sound of your snoring (Quiet) O1 O2 O3 O4 O5 O6 O7 O8 O9 O10 (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

Patient Signature:_____Date:_____

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Informed Consent for the Treatment of Sleep-Disordered Breathing With Oral Appliances

Snoring and obstructive sleep apnea are both breathing disorders that occur during sleep because of the narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may often be no more problematic than the noise itself. However, consistent, loud, heavy snoring has been linked to medical disorders such as high blood pressure. Obstructive sleep apnea is a serious condition; the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. To varying degrees, this can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure, reflux, depression, occasionally heart attack, and stroke.

Because any sleep-disordered breathing may potentially represent a health risk, all individuals will be tested by an overnight sleep recorder in their home or by a polysomnogram in a sleep laboratory.

Oral appliances may be helpful in the treatment of snoring, upper-airway resistance syndrome (UARS), and sleep apnea. Oral appliances are designed to assist breathing by keeping the jaw and tongue forward, thereby opening the airway space in the throat. Though there is documented evidence that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees that this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition, such as nasal obstruction, narrow airway space in the throat, and excess weight. Because each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or apnea for everyone. Polysomnography or other objective tests following treatment will be necessary to confirm effective treatment.

POSSIBLE COMPLICATIONS: Some people may not be able to tolerate the appliance in their mouth. Also, some individuals will develop temporary adverse effects such as excessive salivation, sore jaw joints, sore teeth, or a slight change in their "bite". However, these usually diminish within an hour after appliance removal in the morning. **In rare situations, a permanent "bite" change may occur due to jaw joint changes and/or tooth movement. Generally, this can be prevented with techniques you will be shown. These complications may or may not be fully reversible once appliance therapy is discontinued.** If not, restorative, orthodontic, and/or surgical treatment may be required for which you are responsible. Oral appliances can wear or break. The possibility that these or broken parts may be swallowed or aspirated exists. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use is a hazard to your health and can lead to heart attack, stroke, or even death. See your prescriber before discontinuing use and for recommendations of alternative therapy.

LENGTH OF TREATMENT: The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. Therefore, the device must be worn nightly for a lifetime to be effective. Over time, simple snoring may become worse. Therefore, the appliance may not maintain its effectiveness. The oral appliance needs to be checked at least once a year to ensure proper fit and the mouth examined at that time to assure a healthy condition. **If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation.** Individuals who have been diagnosed as having sleep apnea may notice that after sleeping with an oral appliance they feel more refreshed and alert

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during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high to prevent abnormal heart rhythms and other problems is to be retested with a sleep recorder or polysomnogram.

ALTERNATIVE TREATMENTS: Other accepted treatments for sleep-disordered breathing include behavior modification, weight loss, constant positive airway pressure, and surgery. These alternatives have been explained, and you have chosen oral appliance therapy to treat your particular problem and are aware that it may not be completely effective for you.

UNUSUAL OCCURANCES: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorption, non-vital teeth, muscle spasm, and ear problems are all possible occurrences. Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

I understand my responsibilities to be:

1. to contact Dr. Gillespie immediately if I notice any change (beyond common, transient changes described to me) in my bite, mouth, musculature, or any other tissue or structure possibly associated with the use of this device.
2. to have dental examinations no less frequently than every 6 months.
3. to be compliant with the daily exercises prescribed to me intended to avoid bite changes over time.

I consent to the taking of photographs and x-rays before, during, and after treatment, and their use in scientific papers and demonstrations.

I certify that I have read, or had read to me, the contents of this form. I realize and accept any risks and limitations involved, and do consent to treatment. I give consent for Dr. Gillespie to consult with my physicians regarding this disorder and to exchange my medical records to assist him in the management of my disorder.

Dr. Gillespie _____has _____has not answered all my questions satisfactorily.

DATE: _____ PATIENT: _____

WITNESS: _____

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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 DOB

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: _____