THE CENTER FOR
SLEEP APNEA & TMJ
Idaho's *only Accredited* Dental Sleep Facility

Sleep Apnea & Snoring
TMJ Disorders
Head & Facial Pain

Cameron A. Kuehne, DMD, MS
Jamison R. Spencer, DMD, MS
Keith L. Stucki, DMD, MS

SLEEP SCREENING QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible.

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR. Today's Date:_____

NAME:_____
FIRST MIDDLE INITIAL LAST

ADDRESS:_____ CITY/STATE/ZIP:_____

HOME PHONE:_____ BUSINESS PHONE:_____ ☐ MALE ☐ FEMALE

CELL PHONE:_____ E-MAIL ADDRESS:_____

SOCIAL SECURITY NUMBER:___-___-____ DATE OF BIRTH:___/___/____ AGE:_____

RESPONSIBLE PARTY:_____ PHONE:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

EMPLOYER:_____ ADDRESS:_____

REFERRED BY:_____ ADDRESS:_____

FAMILY PHYSICIAN:_____ ADDRESS:_____

FAMILY DENTIST:_____ ADDRESS:_____

PRIMARY INSURANCE:_____	SECONDARY INSURANCE:_____
POLICY HOLDER:_____	POLICY HOLDER:_____
POLICY HOLDER DOB:_____	POLICY HOLDER DOB:_____

☐ Please check box if you are pregnant or think you might be, and let our office know.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

_____ Frequent heavy snoring
_____ Snoring that affects the sleep of others
_____ Sleep apnea
_____ CPAP intolerance
_____ Significant daytime drowsiness
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nighttime choking spells
_____ Swelling in ankles or feet

_____ I have been told that "I stop breathing" when sleeping
_____ Feeling un-refreshed in the morning
_____ Morning hoarseness
_____ Morning headaches
_____ Nocturnal teeth grinding
_____ Jaw pain
_____ Facial pain
_____ Jaw clicking

Would you be interested in a consult for Invisalign style braces? Yes ☐ No ☐

Other:_____

Office Use Only:
_____ °F
BP:_____
Pulse:_____
Height:_____
Weight:_____

Patient Name _____ Date _____

Patient Name: _____ **Height:** _____ **Weight:** _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

		Yes	No	Not Sure
1.	Have you been told (or noticed on your own) that you snore most nights?	☐	☐	☐
2.	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep, sometimes followed by a GASP?	☐	☐	☐
3.	Are you tired, fatigued or sleepy on most days?	☐	☐	☐
4.	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	☐	☐	☐
5.	Are you overweight?	☐	☐	☐
6.	Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐	☐
7.	Are you currently being treated for OSA?	☐	☐	☐
8.	Are you aware of family history of OSA?	☐	☐	☐
9.	Are you aware of clenching or grinding your teeth at night?	☐	☐	☐
10.	Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?	☐	☐	☐
11.	Do you often feel tired, fatigued or sleepy during daytime?	☐	☐	☐
12.	Has anyone observed you stop breathing during your sleep?	☐	☐	☐
13.	Do you have or are you being treated for high blood pressure?	☐	☐	☐
14.	Are you 50 years old or older?	☐	☐	☐
15.	Does your neck measure more than 15 ¾ inches (40cm) around?	☐	☐	☐
16.	Are you a male?	☐	☐	☐
17.	Do you weigh more for your height than is shown in the table below?	☐	☐	☐

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4'10"	167	5'3"	197	5'8"	230	6'1"	265
4'11"	173	5'4"	204	5'9"	237	6'2"	272
5'	179	5'5"	210	5'10"	243	6'3"	279
5'1"	185	5'6"	216	5'11"	250	6'4"	287
5'2"	191	5'7"	223	6'	258	6'5"	295
Weights shown in the tables above correspond to BMI of 35 for a given height.							

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:

_____

_____

_____

LIST ANY MEDICATIONS AND DOSAGE CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND REASON FOR TAKING THE MEDICATION:

_____

_____

_____

_____

_____

MEDICAL HISTORY

Y☐ N☐ Adenoids removed
Y☐ N☐ Tonsils removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Chronic sinus problems
Y☐ N☐ Chronic fatigue
Y☐ N☐ Congestive heart failure
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent sore throat
Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
Y☐ N☐ Hay fever
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pounding or beating Irregularly during the night
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to face
Y☐ N☐ Injury to mouth
Y☐ N☐ Injury to neck
Y☐ N☐ Injury to teeth
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nighttime sweating
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Shortness of breath
Y☐ N☐ Stroke
Y☐ N☐ Swollen, stiff, or painful joints
Y☐ N☐ TMJ disorder
Y☐ N☐ Thyroid problems
Y☐ N☐ Wisdom teeth extraction

Y☐ N☐ Other medical/dental history _____

_____

_____

_____

Patient Name _____ Date _____

FAMILY HISTORY

Do you have a loved one that has been diagnosed with obstructive sleep apnea and is not currently being treated? Y☐ N☐

Do you have a loved one you think might have undiagnosed sleep apnea? Y☐ N☐

Have any members of your family (blood kin) had:

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

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center? Y ☐ N ☐

Sleep Center Name _____ Location _____ Date of Study _____

CPAP (Continuous Positive Airway Pressure device)

Have you used CPAP? Y☐ N☐ For how long: _____

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to: (mark all that apply)

_____Mask leaks
_____I was unable to get the mask to fit properly
_____Discomfort caused by the strap or headgear
_____Disturbed or interrupted sleep caused by the presence of the device
_____Noise from the device disturbing my and/or bed partner's sleep
_____CPAP restricted movements during sleep
_____CPAP does not seem to be effective
_____Pressure on the upper lip causing tooth related problems
_____A latex allergy
_____Claustrophobic associations
_____An unconscious need to remove the CPAP apparatus at night
_____Other: _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders (weight loss, smoking cessation, surgery, etc.)?

_____

_____

Has any doctor recommended that you have surgery for this condition? Y☐ N☐

SOCIAL HISTORY

How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

How often do you consume caffeine within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Do you smoke? Y ☐ N ☐ If YES, how many a day? _____

Do you use chewing tobacco? Y ☐ N ☐

Patient Name _____ Date _____

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Snoring Disorders

Financial Policy / Insurance Information

It is our goal to treat you with the highest clinical and ethical standards. We have done this for many years in order to warrant the respect of our patients and medical and dental colleagues. Our office has a unique expertise in treating snoring and sleep disorders. Our doctors are some of the highest credentialed and respected doctors in the field.

Our relationship with you and our ability to treat you are our highest concern. Therefore, we are providing you with this financial information.

Snoring is a unique disorder. Snoring without a diagnosis of sleep apnea is not covered under your medical insurance benefits. Therefore a claim for evaluation and treatment with oral appliance therapy for snoring will not be filed with your insurance carrier.

We deal directly with each patient and ask you to pay us for services as they are rendered on a visit-by-visit basis. This means that at the end of your appointment we ask for payment by check, CareCredit, or credit card.

We do realize that for many people payment for needed treatment is a hardship. We will do everything that we can to help you work this out. We offer an extended payment plan or interest free payment plan through CareCredit. If you know that you would like to use such an option, please talk to our office staff and they can give you further information.

We are glad to have you as a patient, and hope to help you with your sleep disorder and that you also have an enjoyable time in our office.

Thank you for your understanding.

I have read and understand the above financial policy and agree to abide by it.

_____

Signature (Parent/Guardian Signature if under 18)

_____ _____

Print Name Date

8119 W. Ustick Rd., Ste. 103, Boise, ID 83704 | 1436 S. Edgewater Cir., Nampa, ID 83686

(208) 376-3600 | fax (208) 376-3616 | www.sleepidaho.com

The Center for Sleep Apnea & TMJ

Sleep Apnea & Snoring – TMJ Disorders – Head & Facial Pain

Notice of Privacy Practices

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

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.

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 medical 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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.

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: Darcie Guy
Telephone: (208) 376-3600 Fax: (208) 376-3616
Address: 8119 W. Ustick Rd., Suite 103, Boise, ID 83704
1436 S. Edgewater Cir., Nampa, ID 83686
E-mail: darcie@sleepidaho.com

The Center for Sleep Apnea & TMJ

Sleep Apnea & Snoring – TMJ Disorders – Head & Facial Pain

Acknowledgement of Receipt of Notice of Privacy Practices

*** You May Refuse to Sign This Acknowledgement***

I hereby acknowledge that I may request a copy of this office's

Notice of Privacy Practices if I require one.

Print Name: _____

Signature: _____

Today's Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- € Individual refused to sign
- € Communications barriers prohibited obtaining the acknowledgement
- € An emergency situation prevented us from obtaining acknowledgement
- € Other (Please Specify)

The Center for Sleep Apnea & TMJ

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Full Name (Please Print Clearly): _____

Patient Date of Birth (mm/dd/yyyy): _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change out privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT