robinwood dental

You may have been diagnosed by your physician as required treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels which in turn may result in the following: Excessive daytime sleepiness, irregular heartbeat, high blood pressure, heart attack or stroke.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring/Obstructive sleep apnea attempts to improve breathing during sleep by keeping the tongue and jaw in a slightly forward position during sleeping hours. Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you since everyone is different and there are many factors influencing the upper airways during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance will give you maximum relief of symptoms. An overnight sleep study will likely be necessary to confirm the effectiveness of 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 use may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term changes in bite. There are also reports of dislodgment 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 changes in the bite that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative dental treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits in our office are mandatory to insure proper fit and allow an examination of your mouth and jaw to assure 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 you cease using the appliance until you are evaluated further.

Alternative Treatment for Sleep-Disordered Breathing

Other accepted treatments for sleep-disordered breathing include behavioral modification, positive airway pressure (CPAP), and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep-disordered breathing, 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 to the doctor. Failure to treat sleep-disordered breathing may increase the likelihood of significant medical conditions .

If you understand the ecplanation of the proposed treatment and have asked the doctor and wuestions you may have about this form of treatment, please sign and date the form below. You will receive a copy.

Signed _____ Date _____

PERMISSION TO USE MEDICAL INFORMATION

It is our goal to always provide you with the highest standards of care. To that end, we are constantly trying to improve the results of our patients who proceed with therapy. Our ability to anonymously use some of the data we collect about you during diagnosis and treatment can be extremely helpful.

Tracking the results of your treatment and comparing it to the treatment of other patients allows us to track outcomes and ultimately provide better service to you and other patients.

We are asking your permission to use the some of the medical information we collect about you for:
- National Studies that look to improve Medical Outcomes for sleep disorders
- Compare your results to the results of other patients so that we can continue to refine our best practices

We greatly appreciate your cooperation. Any of your medical information is used in the strictest confidentiality. Information used for studies is anonymous and used only for statistical analysis.

Your signature below authorizes us to use your medical information for future studies.

Information regarding my diagnosis and therapy related to snoring and other potential sleep disorders can be used anonymously for future studies and outcome analysis.

PLEASE REVIEW IT CAREFULLY.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice described the privacy practices of doctors listed at bottom of form, Sleep Optima which is referred to as “The Provider” in this Notice. This Notice applies only to uses and disclosures of medical information collected by The Provider about persons residing in the United States of America or otherwise subject to the laws of the United States.

The Provider may collect protected health information for use in our sleep apnea information and screening and referral service (the “Service”). The information will be used and disclosed in reviewing your screening information, identifying physician consultants, and sending information to physicians, sleep labs, durable medical equipment suppliers and other health care providers. The Providers will not remove personal identifiers (such as name and address) before disclosing your information to expert physicians or other health care providers. The Provider also may disclose your health information to administrators or others who are involved in operating the Service.

The Provider may disclose your health information or personal information (such as name and address) and health insurance information so that physicians and other health care providers can bill for medical services rendered to you, and to enable us to collecting payments from physicians or other healthcare providers who participate in the Service. We will only disclose the minimum necessary information needed to fulfill this purpose.

The Provider may use or disclose information in order to contact you during the course of providing services to you as either part of the ongoing process or as part of an effort to follow-up with you after using the Service or if there was an opportunity to inform you about additional services that might be of interest to you. We may contact you through the mail, over e-mail or through the phone.

The Provider may disclose protected heath information as required by law.

To receive another copy of this notice, electronically or on paper, call (216)-481-4510 or send a written request to: Sleep Optima, Privacy Office, 17000 St Clair Ave Building 1 Cleveland, OH 44110. The Providers will keep the current policy on the website and available at its offices. If, for any reason, you would like to discuss any matter concerning our privacy policies please contact us.

(Please Print) Patient Name: _____

Signature: _____ Date: _____

SLEEP OPTIMA

DENTAL SLEEP NETWORK
A Division of The Intersoft Group, Inc.

Home Sleep Study Contract

It is important to speak with a Home Sleep Study Specialist prior to receiving your equipment. The specialist can properly prepare you for the study to make sure you get the most accurate results.

Date: _____ Patient Name: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

- ***Late Return Policy*** It is important that the equipment be returned as soon as the home sleep test is complete. You will be provided a return envelope at no expense to you. If not shipped back within seven (7) Days of receipt a late fee of $25 per day will be charged. If the equipment is not returned within thirty (30) days a $3000 assessment may be charged

- ***Damaged Equipment Policy*** Equipment used for your home sleep study is very expensive. It is extremely sensitive and must be used carefully. Equipment damage due to patient negligence is subject to repair fees.

I UNDERSTAND AND ACCEPT THE LATE RETURN POLICY AND THE DAMAGED EQUIPMENT POLICY

Signature:_____ Date:_____

Form 6

Affidavit of Intolerance or Inability to Attempt the CPAP

Patient Name: _____

I have Either attempted to use continuous Positive airway pressure (CPAP) to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis, or I have discussed this treatment option with my specialist and I have decided that I will not be compliant to this option.

I have attempted CPAP and I find it intolerable for the following reasons:

____Does not seem to be effective
____Mask uncomfortable
____Unable to sleep comfortably/fall asleep easily
____Noise disrupts me and/or my spouse /bed partner's sleep
____Claustrophobia
____Pressure on upper lip causes tooth related problems
____Other_____

____Intolerable mask leaks
____Straps/headgear cause discomfort
____Latex allergy
____Tethering disrupts movement (sleep)
____Lifestyle/Job Prevents Usage (i.e. truck driver)
What is your Occupation? _____

Date CPAP therapy started_____
Date CPAP therapy ended_____
Was it paid for by insurance? Y/N

Name of Provider_____
Name of Insurance Co._____

Because of my intolerance/inability to use CPAP therapy, I wish to have an alternative method of treatment. That form of therapy is an Oral Airway Dilator Appliance, as recommended by my sleep study's interpreting physicians and prescribe to me by my dentist.

Patient signature_____Date_____
DDS/DMD Signature _____Date_____

DDS/DMD NOTES REGARDING PATIENT'S CPAP INTOLERANCE OR REASON FOR NOT BEING ABLE TO ATTEMPT THERAPY

_____

_____

_____

_____

☐ This patient does not exhibit any TMJ or other periodontal issues that would cause OAT to be ineffective.

DDS/DMD Initials _____

Form 3

PATIENT INFORMATION

Patient Name:_____DOB:_____

Cell Phone:_____Work Phone:_____

Home Phone:_____Email:_____

Street Address:_____City:_____State:___Zip:_____

Insurance Company:_____Member ID:_____

Group Number:_____Insurance Phone:_____

Policy Holder Name:_____Policy Holder DOB:_____

Primary Care Physician:_____Phone:_____

City:_____State:_____

Have you in the past or are you currently experiencing, being treated for or taking medication for any of the ailments listed below?

___Active Congestive Heart Failure

___Hypertension/High Blood Pressure

___Transplant Ischemia Attacks

___Restless Leg Syndrome

___Nasal Congestion/Hay Fever

___Acid Reflux (GERD)

___Night Sweats

___Depression

___Past Strokes

___Narcolepsy

___Irregular Heartbeat

___Blood Thinners

___Obstructive Sleep Apnea

___Insomnia

___Chronic Lung Disease/Asthma

___Erectile Dysfunction

___Diabetes

___Past Heart Attack/Angina

___Chronic Fatigue

___Oxygen Therapy

SLEEP HEALTH QUESTIONNAIRE

Patient Name: _____

Chief Sleep Complaint

__ Snoring __ Stop breathing during sleep __ Sleep apnea __ Sleepiness

__ Fatigue __ Insomnia __ Other _____

Severity: (circle one) mild / moderate / severe **Duration:** (circle one) weeks / months / years

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Use the following scale to tell us how likely you are to doze: **0 - no chance** **1 - slight chance** **2 - moderate chance** **3 - high chance**

Sitting and reading	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Watching television	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in a public place (such as theatre or a meeting)	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Berlin Questionnaire

Please circle the appropriate letter for each answer.

Do you snore?
a. Yes
b. No
c. Don't know

Snoring loudness
a. Loud as breathing
b. Loud as talking
c. Louder than talking
d. Very loud

Snoring Frequency
a. Almost every day
b. 3 to 4 times per week
c. 1 to 2 times per week
d. 1 to 2 times per month
e. Never or almost never

Does your snoring bother other people?
a. Yes
b. No

How often have you or your spouse noticed pauses in your breathing?
a. Almost every day
b. 3 to 4 times per week
c. 1 to 2 times per week
d. 1 to 2 times per month
e. Never or almost never

Are you tired after sleeping?
a. Almost every day
b. 3 to 4 times per week
c. 1 to 2 times per week
d. 1 to 2 times per month
e. Never or almost never

Are you tired during wake time?
a. Almost every day
b. 3 to 4 times per week
c. 1 to 2 times per week
d. 1 to 2 times per month
e. Never or almost never

Have you ever fallen asleep while driving?
a. Yes
b. No

Do you have high blood pressure?
a. Yes
b. No

Patient Name: _____

Form 4B

SLEEP HEALTH QUESTIONNAIRE - Continued

Sleep Habits

How much time do you spend in bed trying to sleep during a 24-hour period? __ Less than 5 hrs __ 5-7 hrs __ 7-8 hrs __ 8+ hrs

How much of that time do you actually sleep? __ Less than 5 hrs __ 5-7 hrs __ 7-8 hrs __ 8+ hrs

What is your normal bedtime? _____ What is your normal wake-up time? _____

Do you rotate shifts in your job(s)? __ Yes __ No

Sleep Behavior

Do you have difficulty falling asleep? __ Yes __ No

How many times each night do you wake up? __ 0 __ 1-2 times __ 3+ times

Does pain interfere with your sleep? __ Yes __ No

Do you dream? __ Yes __ No

Do you have trouble breathing through your nose at night? __ Yes __ No

Other Sleep Behavior

How often does an uncomfortable urge to move your legs, ("restless legs") make it difficult to fall asleep?

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

If so, does movement temporarily remove the discomfort? __ Yes __ No

I have been told I kick or twitch my legs when asleep.

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

I have been told I grind or clench my teeth when sleeping.

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

Do you wake up in the morning with a headache?

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

Cataplexy

Has strong emotion (surprise, laughter, anger, etc.) ever provoked localized weakness or even a fall?

__ Never __ Rarely __ Occasionally

Sleep Apnea Test & Treatment

Have you ever had a sleep study? __ Yes __ No Results _____

If so, when _____ Where _____

Have you ever been treated with: __ CPAP __ Oral Appliance __ Nasal Surgery __ Throat Surgery

SLEEP OPTIMA
DENTAL SLEEP NETWORK
A Division of The Intersoft Group, Inc.

OSA Screening Form

Patient Name: Date: DOB:

Gender: _____ Height: _____ Weight: _____ BMI: _____

Items below this line and on the next page are for reserved for doctor's evaluation.

Epworth Sleepiness Scale Scoring

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to seek medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

Patients Score: _____

Berlin Questionnaire Scoring

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.

Category 1:

1. Do you snore? If 'Yes', assign 1 point
2. Snoring loudness? If 'c' or 'd' is the response, assign 1 point
3. Snoring frequency? If 'a' or 'b' is the response, assign 1 point
4. Does your snoring bother other people? If 'a' is the response, assign 1 point
5. How often have you or your spouse noticed pauses in your breathing? If 'a' or 'b' is the response, assign 2 points

Category 1 is positive if the total score is 2 or more points!

Patients Score for Category 1: _____

Category 2:

6. Are you tired after sleeping? If 'a' or 'b' is the response, assign 1 point
7. Are you tired during wake time? If 'a' or 'b' is the response, assign 1 point
8. Have you ever fallen asleep while driving? If 'a' is the response, assign 1 point

Category 2 is positive if the total score is 2 or more points!

Patients Score for Category 2: _____

Category 3:

9. Do you have high blood pressure?

Category 3 is positive if the answer is 'yes' OR if the BMI, above, is 30 kg/m2 or more.

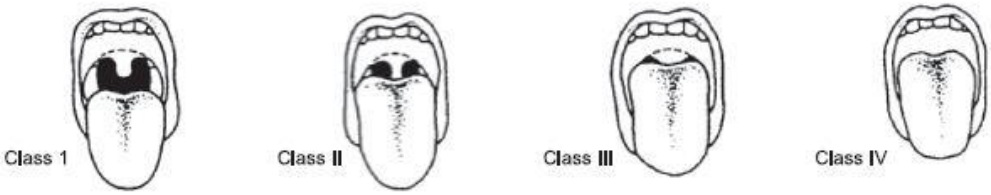
Patients Score for Category 3: _____

Based on category results above please circle risk level of the patient.
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.

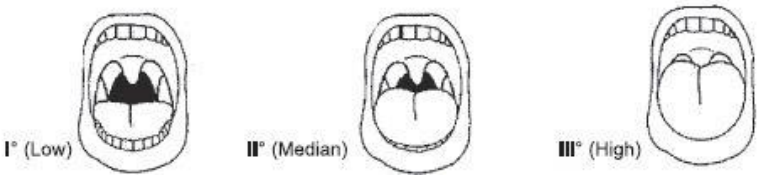
Patients Overall Score: High Risk or Low Risk

 | Fax: 1-877-668-4006

Mallampati Scoring (Circle Appropriate Class Under Image):



Tongue Level (Circle Appropriate Type under Image):



Doctor's Evaluation

Physical Examination: Neck Size___

Elongated/Misshaped Uvula ___ Bruxism ___ Class II Occlusion___ Tori___

Large Tonsils___ Narrow Airway___ Acid Reflux ___

Recommended Next Steps

Diagnostic Sleep Test ___ **Oral Appliance consultation**___

Doctor Notes:

Doctor's Signature: _____

Patient has been made aware that they may be at risk for obstructive sleep apnea and declines further treatment.

Patient Signature: _____

SLEEP OPTIMA DENTAL SLEEP NETWORK
A Division of The Intersoft Group, Inc.

FAX CHECKLIST

Dentist: Dr. Robert P. Renek

Dental Practice: Robinwood Dental Center

Phone Number: 240-313-9660 ext. 206 Tracey

Patient Name: _____

Number of Pages: 10 Date: _____

Undiagnosed Patient

- ☐ Sleep Health Questionnaire (2 pg)
- ☐ Screening Form (2 pg)
- ☐ Patient Information Form
- ☐ HIPAA
- ☐ Readable Copies of Medical Cards
- ☐ Sleep Contract

Diagnosed Patient with Apnea

- ☐ Sleep Health Questionnaire (2 pg)
- ☐ Screening Form (2 pg)
- ☐ Patient Information Form
- ☐ HIPAA
- ☐ Readable Copies of Medical Cards
- ☐ Prior Sleep Study
- ☐ Affidavit of Intolerance to CPAP

If you want any other procedures to be verified with insurance please indicate:
(conebeam, xrays etc…)_____

Fax 1-877-668-4006