Snoring & Sleep Apnea Center of Queens and Nassau - New Patient Form

Patient Information
Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ___

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address_____

Date of Birth (M/D/Y): ____ /____ /_____ Gender: □M □ F

Social Security Number (SSN): _____

The best time to contact me is: □ Morning □ Mid-Day □ Evening on □ Home phone □ Cell phone □ Work phone

Height: Feet_____ Inches_____ Weight (lbs): _____

Marital Status: □ Married □ Single □ Life Partner □ Minor
Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____ Phone_____

REFERRED BY:
_____

Employer Information
Employer: _____Phone: (____) _____Fax: (____)_____
Address: _____
City_____ State: _____Zip: _____

Health Insurance Information
Patient's Relationship to Primary Insured: □ Self □ Spouse □ Child □ Other
Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____ /____ /_____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address_____ City_____ State: _____ Zip _____
Phone: (_____)_____Fax: (_____)_____
Email: _____
Please present your insurance card so we can photocopy it.

Secondary Health Insurance
DO YOU HAVE SECONDARY INSURANCE? □ YES □ NO
IF **YES**, PLEASE COMPLETE THIS SECTION
Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other
Name of Insured (First, MI, Last): _____ Insured DOB___ /___ /_____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address_____
City_____ State: _____ Zip _____
Phone :(_____)_____ Fax: (_____)_____
Email: _____
Please present your secondary insurance card so we can photocopy it.

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Medical Contacts
Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____

PHONE: _____ FAX: _____

ADDRESS: _____

ENT: _____

PHONE: _____ FAX: _____

ADDRESS: _____

SLEEP DOCTOR: _____

ADDRESS: _____

DENTIST: _____

PHONE: _____ FAX: _____

ADDRESS: _____

OTHER MD: _____

PHONE: _____ FAX: _____

ADDRESS: _____

OTHER MD: _____

PHONE: _____ FAX: _____

ADDRESS: _____

I certify this information is true, accurate, and complete to the best of my knowledge.
INTIAL: _____ Date: _____

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EPWORTH SLEEPINESS SCALE

Sitting and Reading	_____	0 = No chance of dozing
Watching TV	_____	1 = Slight Chance of dozing
Sitting inactive in public place (theater)	_____	2 = Moderate Chance of dozing
As a car passenger for an hour without a break	_____	3 = High Chance of dozing
Lying down in the afternoon to rest	_____	
Sitting and talking to someone	_____	
Sitting quietly after lunch without alcohol	_____	TOTAL = _____
In a car while stopped at a traffic light	_____	

THORNTON SNORING SCALE

My snoring affects my relationship with my partner	_____	0 = Never
My snoring causes my partner to be irritable or tired	_____	1 = 1 night/week
My snoring requires us to sleep in separate rooms	_____	2 = 2-3 nights/week
My snoring is loud	_____	3 = 4+ nights/week
My snoring affects people when I am sleeping away from home	_____	TOTAL = _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

_____

Do you have other complaints?

- ☐ 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
- ☐ Other: _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

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? YES / NO / SOMETIMES

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? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

Do you have a bed partner? YES / NO / SOMETIMES **Do you sleep in the same room?** YES / NO

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

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Have you ever had a sleep study? YES NO
If YES, where and when? _____ **Date:**_____

Have you tried CPAP? YES NO
Are you currently using CPAP? YES NO
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

If you use or have used CPAP, what are your chief complaints about CPAP?

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort from the straps or headgear
- ☐ Decrease sleep quality or interrupted sleep from CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI / stomach / intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ The device causes irritation due to air leaks
- ☐ Other:

_____
_____

Are you currently wearing a dental device? YES NO
Have you previously tried a dental device? YES NO
If YES, was it Over the Counter (OTC)? YES NO
Was it fabricated by a dentist? YES NO **If YES, who fabricated it?** _____

If applicable, please describe your previous dental device experience:
_____

Have you ever had surgery for snoring or sleep apnea? YES NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.
_____
_____
_____

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PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures? YES NO
If YES, what medication(s) and why do you require it? _____

ALLERGENS -- Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

_____

MEDICATIONS -- Please list all medications you are currently taking:

_____

MEDICAL HISTORY – Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

_____
_____
_____

Dental History

How would you describe your dental health? EXCELLENT GOOD FAIR POOR
Have you ever had teeth extracted? YES NO → **If YES, please describe**_____
Do you wear removable partials? YES NO
Do you wear full dentures? YES NO
Have you ever worn braces (orthodontics)? YES NO → **If YES, date completed:** _____
Does your TMJ (jaw joint) click or pop? YES NO → **Do you have pain in this joint?** YES NO
Have you had TMJ (jaw joint) surgery? YES NO
Have you ever had gum problems? YES NO → **If YES, have you ever had gum surgery?** YES NO
Do you have dry mouth? YES NO
Have you ever had an injury to your head, face, neck, or mouth? YES NO
Are you planning to have dental work done in the near future? YES NO
Do you clench or grind your teeth? YES NO
If you answered YES to any question above, please briefly describe your answer here:

_____
_____

Family History

Have genetic members of your family had:
Heart Disease? YES NO **High Blood Pressure?** YES NO **Diabetes?** YES NO
Have genetic members of your family been diagnosed or treated for a sleep disorder? YES NO
How often do you consume alcohol within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
How often do you take sedatives 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? YES NO **If YES, how many packs per day?** _____
Do you use chewing tobacco? YES NO **If YES, how many times per day?** _____

PATIENT SIGNATURE

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.
Patient or Guardian Signature: _____ Date: _____

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization. I hereby assign and convey directly to the below-named health care provider ("Provider"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of its managed care network participation status.

I understand that I am financially responsible to the Provider for any charges regardless of health care benefits. It is my responsibility to notify the Provider of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I hereby authorize the Provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the Provider or its attorneys in order to claim such medical benefits.

In addition, I also assign and/or convey to the Provider any legal or administrative claim or choose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the Provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the Provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

PROVIDER: K Scott Danoff, DMD, 49-33 Little Neck Parkway, Little Neck, NY 11362

Patient Signature
I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Print Name: _____

Patient / Guardian Signature: _____ **Date**: _____

AFFIDAVIT FOR INTOLERANCE TO CPAP

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

___Mask leaks

___An inability to get the mask to fit properly

___Discomfort or interrupted sleep caused by the presence of the device

___Noise from the device disturbing sleep or bed partner's sleep

___CPAP restricted movements during sleep

___CPAP does not seem to be effective

___Pressure on the upper lip causes tooth related problems

___Latex allergy

___Claustrophobic associations

___An unconscious need to remove the CPAP apparatus at night

Other_____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).
Print Name: _____

Signature: _____

Date: _____