Snoring & Sleep Apnea Medical Questionnaire

Complete all forms BEFORE your appointment. If you do not, you may be rescheduled

Items to bring to the first appointment:
1. **Your insurance card (we will need to copy the card)**
2. **A picture ID (such as a driver license) and this form**

Patient information: (please print legibly in **black ink** – this is a legal document) Date: _____

_____ _____ _____ ____ / ____ _____ ____
Last Name First Name MI Male / Female Date of Birth Age

Patient Health Information:

1. Please check the following list of symptoms as applicable:

	Yes	Occasional	No		Yes	Occasional	No
Jaw and/or facial pain	( )	( )	( )	Pain inside mouth	( )	( )	( )
Difficulty opening or closing jaw	( )	( )	( )	Sore throat or difficulty swallowing	( )	( )	( )
Clicking sound in either jaw joint	( )	( )	( )	Dizzy or lightheaded	( )	( )	( )
Bite feels off	( )	( )	( )	Teeth pain	( )	( )	( )

Other condition not listed: _____
Your height: _____ ; weight:_____ lbs; Neck collar size_____

Do you have headaches? Y N If yes, circle all that apply to your headaches:
nausea vomiting light sensitivity sound sensitivity
have to lie down miss work/school causes tearing

2. Sleep:

How many hours per night (on average)? _____			Do you have difficulty concentrating/focusing on tasks?	Y	N
Do you have difficulty staying asleep?	Y	N	Do you use sleeping pills?	Y	N
Do you feel frequently fatigued?	Y	N	Do you snore?	Y	N
Does someone snore disturb your sleep?	Y	N	Do you feel refreshed in the morning?	Y	N
Do you have difficulty getting to sleep?	Y	N	Do you feel sleepy when driving?	Y	N
Are your legs restless at bedtime?	Y	N	Do you have headaches when waking in morning?	Y	N
Have you been observed to choke, gasp or stop breathing when you sleep?				Y	N

Please rate how likely you are to doze off or fall asleep in the following situations. Use the scale to rate how likely you are to fall asleep with each particular activity. **Even if you have not been in that situation lately, estimate how it would affect you**.

0 - would never doze **1** – slight chance of dozing **2** – moderate chance of dozing **3** – high chance of dozing

Sitting and reading	_____	Sitting inactive in a public place (theater, meeting, library)	_____
Watching TV	_____	As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____	Sitting quietly after lunch (without alcohol)	_____
Sitting and talking to someone	_____	In a car, while stopped for a few minutes in traffic	_____
		TOTAL	_____

Have you ever had a sleep study? Y N If yes, who performed the test? (clinic / doctor) _____

When (approximately)? _____ What were the results? _____

Circle all of the past treatments that you have tried for your sleep apnea:
CPAP Throat Surgery (UPPP) Jaw Surgery (type): _____
Weight Loss Sleep Position Changes Dental Appliances/Splints Other: _____
Which treatments are you still using? _____ Why did you stop above treatments? _____

NAME (Last) _____ **(First)** _____

Please circle any of the following that apply to you, past or current:

1.	**General Constitution:**	Weight change Loss of appetite Blurred vision Trouble sleeping
2.	**Eyes:**	Visual changes Blurred vision Double vision Pain Light sensitivity Drainage Redness Glaucoma Watery eyes Tearing
3.	**Ears:**	Hearing problems Pain Drainage Ringing Clicking/Popping Dizziness Tinnitus Vertigo
	Nose:	Change in sense of smell Congestion Nose bleeds Facial pain Nasal drainage Sinus Pain
	Mouth & Throat:	Voice changes Teeth pain Bleeding/Swollen gums Change in sense of taste Sore throat Difficulty swallowing Jaw Clicking/Popping Dental problems Dentures Laryngeal problems
4.	**Skin:**	Rashes Itching/change in texture Change in size, color, discharge of mole Birthmarks Change in skin, hair or nails
5.	**Cardio Vascular:**	Chest pain Chest palpitations Difficulty breathing while lying down Swelling in legs or feet High blood pressure Congestive heart failure History of heart attack / heart disease / coronary artery disease Heart murmur Valve replacement Stent Heart valve replacement Rheumatic fever
6.	**Gastro Intestinal:**	Nausea Reflux Loss of appetite Difficulty swallowing Ulcers Liver Disease
7.	**Genitourinary:**	Pregnant - Trimester 1 2 3 Birth control Hysterectomy Menopause Breast feeding Kidney Disease
8.	**Respiratory:**	Snoring Sleep Apnea Restless leg syndrome Bronchitis Asthma Shortness of breath Pain with breathing Cough Fatigued Tired/Groggy Emphysema Pneumonia Tuberculosis
9.	**Endo:**	History of diabetes Thyroid problems Unplanned weight loss/gain Feeling excessively cold/hot Increase in thirst/urination Abnormal hair growth High Cholesterol HIV/AIDS Hepatitis Hemophilia Anemia Prolonged bleeding Cancer
10.	**Musc/Skel:**	Joint swelling/pain Muscle aches Cramps Headaches Neck pain Rheumatoid Arthritis Osteoarthritis Psoriatic Arthritis Fibromyalgia Lyme's disease Raynaud's Disease
11.	**Neuro:**	Problems with coordination/walking/memory/weakness Dizziness/blackout/seizures Tremors Numbness or tingling Concussion Epilepsy Seizures Traumatic Brain Injury Headaches Slurred speech Stroke Parkinsonism Multiple sclerosis (MS) Migraines Traumatic brain injury (TBI)
12.	**Psych:**	Feeling of sadness Difficulty sleeping Mood changes Unusual headache Worry Panic Loss of appetite Anger Depression Anxiety Suicidal Thoughts Tension Drug Addiction Psychiatric treatment Psychological counseling
13.	**Allergy:**	Sneezing Itchy/Watery eyes Runny nose Seasonal Latex allergy Food allergy Medication allergy:

NAME (Last) _____ **(First)** _____

Past Medical History:

List all current medications (prescriptions, over the counter medicine, herbs, vitamins, etc) or attach a list of medications to this form

_____ _____ _____ _____ _____

List medication allergies and type of reaction (i.e., rash, itching, difficulty breathing, etc.)

_____ _____ _____ _____ _____

Surgeries & Hospitalizations:

_____ _____ _____ _____ _____

Traumas (what type & when):

_____ _____ _____ _____ _____

Dental care:
Are you currently under dental care? Y N If yes, last dental check-up (dentist/date): _____
Do you have any pending dental work? Y N If yes, please explain: _____
Do you have any loose teeth? Y N

Do you have any problems with a dental prosthesis (crowns, bridges, partial dentures, implants)? Y N If yes, explain: _____

Do you wear an upper and/or a lower denture or partial denture? Y N

Family History:

Circle any of the following that a family member has or had (mother/father/brother/sister/grandparents)

Migraines Sleep Apnea TMJ Arthritis Cancer Diabetes Heart attack Stroke

Are you (circle one) Single Married Divorced Widowed No. of children _____

Occupation _____ How many years _____ Hobbies_____ Disabled? Y N

Health : Exercise: Do you get regular aerobic exercise? Y N If yes, how many days per week on average _____

Nutrition (describe):

Habits: Caffeine consumption? None _____; coffee ____drinks per day; soda ____drinks per day; tea ____drinks per day

Excedrin (or other pain medications with caffeine) _____pills per day
Stay awake drugs _____ Other: _____
Do you use sleeping pills? Y N If yes, how often and how many? _____

Tobacco use, how much? None cigarettes _____ other_____
How much alcohol? None _____ drinks per day / week / month
Chewing gum use, how often? None daily weekly monthly

Stress: What is your average stress level? low / moderate / high Does stress affect your pain level? Y N

_____ _____ _____ _____

Patient's Signature **Date** **Doctor's Signature** **Date**

SNORING & SLEEP APNEA TREATMENT CENTERS:

It is very important to keep your doctors informed of your care. We would like to forward a copy of our report to them.

Please <u>initial</u> beside each doctor's name that you will allow us to send a report.

1. Referring Doctor: _____ _____ initial here to allow a
   Office name / Address: _____ report to be sent to this doctor
   Phone: _____

2. Sleep clinic doctor: _____ _____ initial here to allow a
   Office name / Address: _____ report to be sent to this doctor
   Phone: _____

3. Primary Doctor: _____ _____ initial here to allow a
   Office name / Address: _____ report to be sent to this doctor
   Phone: _____

4. Primary Dentist: _____ _____ initial here to allow a
   Office name / Address: _____ report to be sent to this doctor
   Phone: _____

5. Other Provider you are in care with _____ _____ initial here to allow a
   Office name / Address: _____ report to be sent to this doctor
   Phone: _____

6. Other Provider you are in care with: _____ _____ initial here to allow a
   Office name / Address: _____ report to be sent to this doctor
   Phone: _____

7. Any other Physicians, Dentists, Chiropractors, Therapists or locations you would like a copy of a report sent to:
   Name: _____
   Address: _____ _____ initial here to allow a
   Phone: _____ report to be sent to this person

How did you hear about us?

Friend/Family Member: _____
Address: _____
Phone: _____

	Doctor listed in #1 above		One of our office staff/employees *
	Insurance book		Sign
	Newspaper		Magazine
	Radio		Television
	Healthwise publication		Coupon
	Yellow pages		
	Web / Internet		

Other: _____

*Name: _____ Phone #: _____

_____ _____
Signature Date

_____
Print Name

Office Use Only: Initials_____ Location_____ Account#_____ Scanned_____

SNORING & SLEEP APNEA TREATMENT CENTERS

Financial Policy

Patient's Name: _____, Date of Birth: _____

Billing & Financial Information:

A copy of your insurance card is required at each visit. If you do not have your insurance card(s) you may be asked to pay in full at or prior to the performance of services. I authorize the Snoring and Sleep Apnea Treatment Centers /LMG, Inc. ("S-SA Centers"), to submit the charges to my insurance company for services, except for device repairs which are at my own expense. It is my responsibility to notify the S-SA Centers of any changes in my insurance coverage.

I understand and have been notified in advance that Drs.Mackman, McDaniel, Tache, Mier and the Snoring & Sleep Apnea Treatment Centers are NOT Medicaid providers. I understand and agree that I am financially responsible to the S-SA Centers for any charges not covered by my insurance or Medicaid, including all co-pays, co-insurance and deductibles and any balance of the bill if the submitted claims or any part of them are denied for payment by my insurer or if the submitted claim(s) are processed as not medically necessary by my healthcare insurer. Services rendered by Affiliated Health, Pain Rehabilitation Associates, Radiology and Dental Imaging Centers, and/or Physical Therapy are billed separately and are not included in your S-SA Centers billing. The S-SA Centers reserves the right to apply patient payments between corporations (LMG, Inc. /Affiliated Health of Wisconsin, Ltd.) unless otherwise requested in writing by you.

Appliance Billing & Financial Information:

We encourage you to check your insurance plan regarding benefits available for the non-surgical treatment of snoring and sleep apnea. As a courtesy to you, our patient, we contact your insurance company to verify your benefits for the treatment that has been recommended for you. This verification includes requesting information about any deductibles, coinsurances, benefit limitations or exclusions that apply to you. Using this insurance information, we calculate an estimate of what we anticipate your out of pocket expense might be for your appliance treatment.

Be advised that your health insurance company does not guarantee benefits until they receive your claims. The S-SA Centers does NOT determine whether services are paid for under your insurance policy. Therefore, this estimate cannot be considered the only amount you will owe and your final balance may increase or decrease based on how your insurance company processes the claims.

This estimate includes: Patient responsibility for the impressions and bite, lab fees, the appliance itself, and fitting of the appliance.

This estimate does NOT include: Patient responsibility for your Initial visit, your treatment consult, diagnostic imaging, follow-up office visits, or any care/treatment/evaluation received in the Pain Management or Physical Therapy clinics through Affiliated Health of Wisconsin (if needed).

The estimated fee is due upon the fit of the appliance.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for the missed appointments at the rate of a normal office visit. This is billed directly to you, the patient. Insurance companies do not cover missed appointments.

Return/Repair Policy:

All custom fitted appliance sales are final. I, the undersigned, agree that if I choose not to continue with the fit of the appliance after it has been custom made, I will be personally responsible for a cash payment of $500, which is not billable to my insurance plan. All repairs are subject to a separate charge and are not billable to my insurance plan.

Medical Consent:

I, the undersigned, hereby consent to medical care from the SLEEP Centers including, but not limited to: examinations, X-rays, medical treatments, administration of medications and appliances, as are, in the judgment of the treating practioner, medically advisable for the patient identified above. I understand that no guarantee has been made as to the results of the care, treatment and medications of the patient.

I have read and I understand and agree with this financial policy. I understand that the estimated cost for my appliance is due upon the fit of the appliance. I understand that this may not be the only amount due for services received and that the estimated cost does NOT include any visits in the Snoring & Sleep Apnea department or services received in the x-ray department, Pain Management or physical therapy department. I guarantee payment of all charges incurred for this account. I understand that I am fully responsible to pay any amounts not paid by my insurance company for any reason. I understand that the costs and expenses are solely for the proposed treatment and do not include costs that may be incurred for treatment complications that may arise or other dental care that may be required due to the use of an oral appliance. I further agree that the S-SA Centers may reschedule my appointment should I refuse to make payment as described in this Financial Policy. I further agree to pay any attorney fees, court costs, and related fees incurred should collection efforts be commenced to collect any unpaid portion of my bill. I also understand that benefits discussed in the office are not a guarantee of payment by my insurance company. This authorization is in effect until I choose to revoke it in writing.

_____ _____

Signature of Patient/Parent/Guardian/Personal Representative Date

Patient's Name: _____, Date of Birth: _____

For Minor Patients Only:

The parent/guardian/personal representative seeking or authorizing treatment is responsible for paying for such treatment. If payment for services is to be paid by someone else, then the parent, guardian or personal representative bringing the child for services must pay and have the other party reimburse them.

I, _____ hereby authorize and consent to the performance of examinations, procedures and treatments
Name of Parent/Guardian/Personal Representative

for _____, which the TMJ Centers' practitioner may deem necessary.
(Patient's name)

This consent shall remain in effect until I revoke it in writing.

_____ _____

Signature of Parent/Guardian/Personal Representative Date

_____

Description of Parent/Guardian/Personal Representative

TMJ & OROFACIAL PAIN TREATMENT CENTERS OF WISCONSIN HIPAA1
SNORING AND SLEEP APNEA TREATMENT CENTERS
AUTHORIZATION FOR RELEASE OF
PATIENT-IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____ DOB: _____ Acct # :_____

I authorize The TMJ & Orofacial Treatment Centers of Wisconsin and the Snoring and Sleep Apnea Treatment Centers (TMJ & SA Centers) the use or disclosure of the above-named individual's health information as described. I understand that I have the right to refuse to provide any authorized person(s).

Due to HIPAA regulations, enacted to safeguard the privacy of patient health information, the TMJ &SA Centers are permitted to disclose your protected health information in the provision, coordination or management of your health care. The TMJ & SA Centers are authorized to disclose your protected health information for treatment, payment or health care operations.

Additionally, please indicate below, if there is anyone in your household – including your spouse – to whom the TMJ & Orofacial Treatment Centers and the Snoring and Sleep Apnea Treatment Centers may speak to regarding past, present and future information related to appointments, treatment, prescription refills, test results and/or payment issues.

I give the following named person(s) authorization to take messages or speak with the TMJ & Orofacial Treatment Centers and the Snoring and Sleep Apnea Treatment Centers on my behalf regarding (please check):

□ **Appointments,** □ **Financial,** □ **Medical,** □ **Insurance,** □ **All**

Name of authorized Person: _____ Relationship: _____

Name of authorized Person: _____ Relationship: _____

Name of authorized Person: _____ Relationship: _____

□ Emergency contact listed on my registration form: _____

_____ Initial I authorize the use and disclosure of my name, photographic/video/x-ray images, and/or testimonial for marketing (social media and/or advertising) and research/educational purposes by the practice name listed above. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

I, _____ acknowledge and understand that this information will be kept in my medical record and that this consent will remain in effect until further notice is given in writing. It is my responsibility to notify the TMJ & Orofacial Treatment Centers and the Snoring and Sleep Apnea Treatment Centers should I wish to change any of the contacts listed above.

_____ _____ _____
Signature of patient or personal representative Relationship if not patient Date