

Patient Registration

Today's Date _____

Patient Information

First Name _____	Last Name _____	M.I. _____				
Street Address _____						
City, State, Zip _____						
Home Phone _____	Work Phone _____	Cell Phone _____				
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
Birth Date _____	Soc Sec # _____	Driver's License # _____				
Email _____	Spouse Name _____					
Employment Status	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired			
Student Status	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/>			
Height	Feet _____	Inches _____	Weight _____ lbs.			

Medical/Dental Professional Information

Primary Care Physician Name _____	City, State _____
Dentist Name _____	City, State _____
Other Physicians and their Specialty _____	

Whom may we thank for referring you to our practice? _____

Medical Insurance Information

First Name _____	Last Name _____	M.I. _____	
Policy/Group No. _____	Relationship to Insured	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
Insurance ID No. _____		<input type="checkbox"/> Child	<input type="checkbox"/> Other
Insured Soc Sec No. _____	Insured Birth Date _____		
Employer Name _____	Driver's License # _____		
<i>Insured Address and Phone Number if different than patient</i>			
Street Address _____			
City, State, Zip _____			
Home Phone _____	Work Phone _____	Cell Phone _____	

Secondary Medical Insurance Information

First Name _____	Last Name _____	M.I. _____	
Policy/Group No. _____	Relationship to Insured	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
Insurance ID No. _____		<input type="checkbox"/> Child	<input type="checkbox"/> Other
Insured Soc Sec No. _____	Insured Birth Date _____		
Employer Name _____	Driver's License # _____		
<i>Insured Address and Phone Number if different than patient</i>			
Street Address _____			
City, State, Zip _____			
Home Phone _____	Work Phone _____	Cell Phone _____	

Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____
First Middle Initial Last

TODAY'S DATE _____

DATE OF BIRTH: _____

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching diagnosis and determining the source of your problem. Please take your time and answer each question a completely and honestly as possible. Please sign each page.

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

Y <input type="checkbox"/>	N <input type="checkbox"/>	Antibiotics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Latex	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sedatives
Y <input type="checkbox"/>	N <input type="checkbox"/>	Aspirin	Y <input type="checkbox"/>	N <input type="checkbox"/>	Local anesthetics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sleeping pills
Y <input type="checkbox"/>	N <input type="checkbox"/>	Barbiturates	Y <input type="checkbox"/>	N <input type="checkbox"/>	Metals	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sulfa drugs
Y <input type="checkbox"/>	N <input type="checkbox"/>	Codeine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Penicillin			
Y <input type="checkbox"/>	N <input type="checkbox"/>	Iodine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Plastic			

Other _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY: (Please indicate dates on items marked current or past)

Medical condition	Never	Current	Past	If past, enter date	Medical condition	Never	Current	Past	If past, enter date
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaw joint surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meniere's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle shaking (tremors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Needing extra pillows to help breathing at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervous system irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Numbness of fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature _____

Date _____

Medical condition	Never	Current	Past	If past, enter date
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent stressful situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
General anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medical condition	Never	Current	Past	If past, enter date
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prior orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Slow healing sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling in ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen, stiff or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendency for ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendency for frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendency for sore throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsils Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wisdom teeth (third molar) extraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other _____	Current	Past	If past, enter date
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

_____	Current	Past	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

ADDITIONAL MEDICAL HISTORY ITEMS:

Recreational drugs	Never	Current	Past	If past, enter date
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

HIV/AIDS	Never	Current	Past	If past, enter date
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y <input type="checkbox"/> N <input type="checkbox"/>	Appendectomy
Y <input type="checkbox"/> N <input type="checkbox"/>	Back
Y <input type="checkbox"/> N <input type="checkbox"/>	Ear
Y <input type="checkbox"/> N <input type="checkbox"/>	Gallbladder
Y <input type="checkbox"/> N <input type="checkbox"/>	Heart

Y <input type="checkbox"/> N <input type="checkbox"/>	Hernia repair
Y <input type="checkbox"/> N <input type="checkbox"/>	Knee Surgery
Y <input type="checkbox"/> N <input type="checkbox"/>	Lung
Y <input type="checkbox"/> N <input type="checkbox"/>	Nasal
Y <input type="checkbox"/> N <input type="checkbox"/>	Periodontal

Y <input type="checkbox"/> N <input type="checkbox"/>	sinus surgery
Y <input type="checkbox"/> N <input type="checkbox"/>	stent implant/heart
Y <input type="checkbox"/> N <input type="checkbox"/>	Thyroid
Y <input type="checkbox"/> N <input type="checkbox"/>	Tonsillectomy
Y <input type="checkbox"/> N <input type="checkbox"/>	Uvulectomy

Other _____	_____	_____
_____	_____	_____

FAMILY HISTORY Has any member of you family had (parent, sibling or grandparent):

Yes No Cancer

Yes No Obesity

Yes No Heart disease

Yes No Thyroid trouble

Yes No Diabetes

Yes No Father snores

Yes No High blood pressure

Yes No Mother snores

Yes No Stroke

Yes No Father has sleep apnea

Yes No Sleep disorder

Yes No Mother has sleep apnea

Other _____

SOCIAL HISTORY:

Tobacco Use: Cigarettes Never smoked

Current smoker
packs per day _____
of years _____

Quit
When did you quit?

Other tobacco: Pipe Snuff Cigar Chew

Alcohol Use: Do you drink alcohol? Yes No If yes, # of drinks per week: _____

Caffeine Intake: None Coffee/Tea/Soda # cups per day: _____

Additional:

Yes No Regular exercise

Epworth Scale & Patient History

Patient Name: _____ Date: _____
 Age: _____ DOB: _____ Height: _____ Ft.
 Weight: _____ Lbs. Neck Size: _____ In. Waist Size: _____ In.

Using the scale provided, please answer how likely you are to doze off or fall asleep in the following situations:

- 0 = Would Never Doze
- 1 = Slight Chance of Dozing
- 2 = Moderate Chance of Dozing
- 3 = High Chance of Dozing

Sitting and reading.	_____
Watching TV.	_____
Sitting inactive in a movie/meeting.	_____
Riding in a car as a passenger for more than an hour without a break.	_____
Lying down to rest in the afternoon.	_____
Sitting and talking to someone.	_____
Sitting quietly after lunch without alcohol.	_____
In a car, while stopped for a few minutes in traffic.	_____
Total	_____

Please mark if you suffer from or have been told you have any of the following:

_____ Loud Snoring	_____ Frequent Nighttime Urination	_____ Diabetes
_____ Witnessed Apnea	_____ Daytime Tiredness	_____ COPD
_____ Obesity/Weight Gain	_____ Depression	_____ Thyroid Dysfunction
_____ Wake up Coughing	_____ High Blood Pressure	_____ Lack of Energy
_____ Never Feel Rested	_____ Headaches in Morning	_____ CPAP Intolerance
_____ Acid Reflux	_____ Decreased Concentration	

For Women Only:

_____ Pregnant	_____ Postmenopausal	_____ Polycystic Ovary Syndrome (PCOS)
_____ Premenopausal	_____ Hysterectomy	

For Office Use Only _____

Enlarged Tonsils:

No: _____
 Yes: _____
 What Size? _____

BMI: _____
 Blood Pressure: _____ Pulse: _____

Mallampati Classification:

Class 1: _____
 Class 2: _____
 Class 3: _____
 Class 4: _____



Class 1 Class 2 Class 3 Class 4

Sleep Consultation

Name: _____ Today's Date _____
 First Middle Initial Last

Date Of Birth: _____ / _____ / _____ Male Female

What Are Your Chief Complaints For Which You Are Seeking Treatment?

Please number your complaints with #1 being the most severe, #2 the next most severe, etc. You may assign the same number more than once. You do not need to number every item, only those which present as your chief concerns.

SLEEP BREATHING COMPLAINTS

Number

- _____ CPAP Intolerance
- _____ Daytime Tiredness
- _____ Difficulty Falling Asleep
- _____ Fatigue
- _____ Decreased concentration
- _____ Depression
- _____ High Blood Pressure
- _____ Gasping When Waking Up
- _____ Loud Snoring
- _____ Never Feel Rested
- _____ Nighttime Choking Spells
- _____ Obesity
- _____ Significant Daytime Drowsiness
- _____ Sleepy While Driving
- _____ Witnessed Apneic Events
- _____ Frequent Heavy Snoring

TMD/PAIN COMPLAINTS

Number

- _____ Difficulty Swallowing
- _____ Dizziness
- _____ Facial Pain
- _____ Headaches
- _____ Jaw Clicking
- _____ Jaw Locking
- _____ Jaw Pain
- _____ Limited Mouth Opening
- _____ Migraines
- _____ Morning Head pain
- _____ Morning Hoarseness
- _____ Neck Pain
- _____ Nocturnal Teeth Grinding
- _____ Pain When Chewing
- _____ Ringing In the Ears
- _____ Frequent Heavy Snoring affecting sleep of others

Sleep Studies

Have you ever had an evaluation at a Sleep Center? Yes No

If Yes, Please complete the "Sleep Records Request Form" on the next page.

Have you been previously diagnosed with Obstructive Sleep Apnea?

If yes, how long ago was it? _____ Years Ago Months Ago Days ago

Other Therapy Attempts

What other therapies have you had for breathing disorders?

YES	NO	
		Dieting
		Weight Loss
		Surgery (Uvuloplasty)
		Surgery (Uvulectomy)
		Pillar procedure
		Smoking cessation
		CPAP
		BiPap
		Uvulectomy (but continues to have symptoms)
		Uvuloplasty (but continues to have symptoms)

CPAP Intolerance (Continuous Positive Airway Pressure Device)

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

YES	NO	
		Masks leaks
		Inability to get the mask to fit properly
		Discomfort from headgear
		Disturbed or interrupted sleep
		Noise disturbing sleep 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
		Latex allergy
		Claustrophobic associations
		An unconscious need to remove the CPAP
		Unable to sleep well
		Does not resolve symptoms
		Noisy
		Cumbersome

 Patient Signature (or parent if child)

 Date



Sleep Records Request Form

I, _____, having Social Security

_____ and Date of Birth _____,

authorize release of my sleep record(s) to:

Illinois Institute of Dental Sleep Medicine
11825 N State Route 40, Suite 100
Dunlap, IL 61525
Phone: 309-243-8980
Fax: 309-243-8983

My current address is:

_____ (street address)

_____ (city, state, zip code)

_____ (phone #)

Sleep Facility Information:

_____ (Name)

_____ (City, State)

Patient Signature (or parent if child)

Date

Dear Patient,

For you to receive the most complete care, it is important for doctors to communicate with one another about the treatment they are providing. Please provide the names and addresses of any doctors with which you would like us to share your progress notes and diagnostic reports. Thank you!

Patient Name _____ DOB _____ Date _____

	For Future Office Use:	For Future Office Use:	For Future Office Use:	For Future Office:
<i>Please put the doctor's names and addresses below:</i>	<i>Letter #1 initial, and additional information</i>	<i>Letter #2 delivery, and additional information</i>	<i>Letter #3 release, and additional information</i>	<i>Additional letters, and additional information</i>
<i>Dentist:</i>				
<i>Primary Care Physician:</i>				
<i>Specialist 1:</i>				
<i>Specialist 2:</i>				

Chief complaints _____ %reduced _____

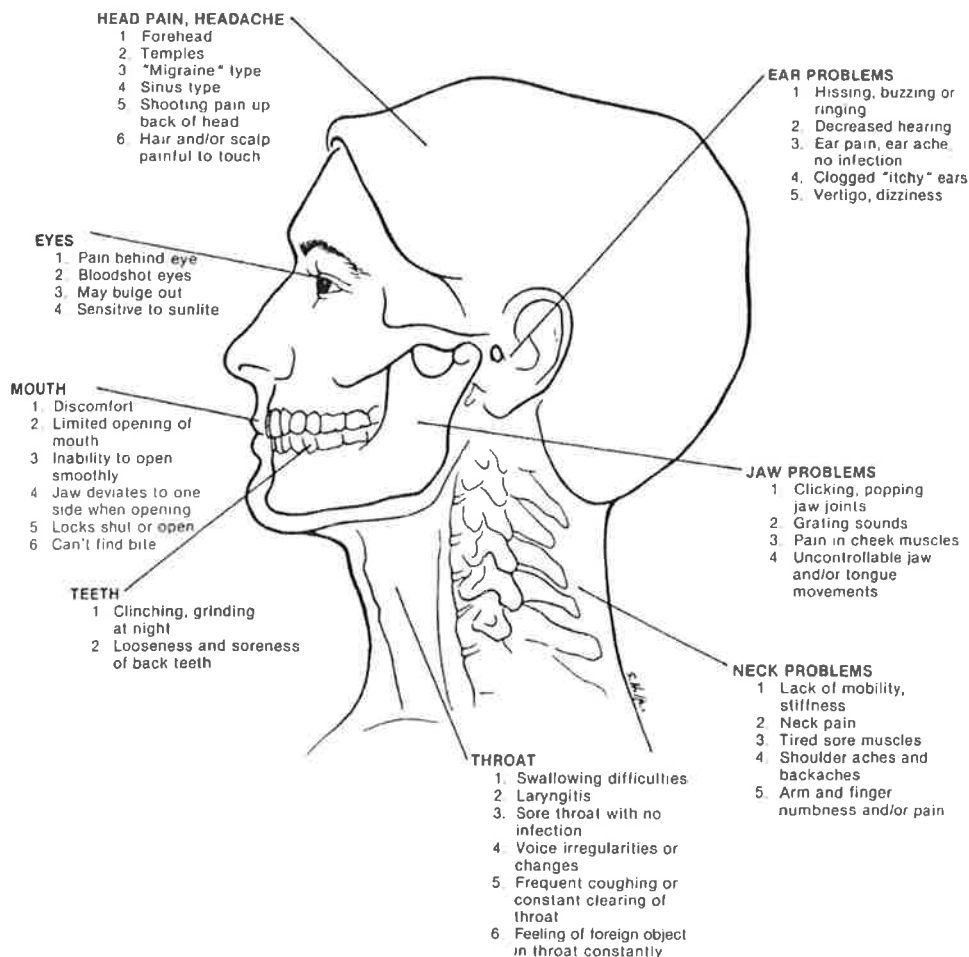
FOR OFFICE USE ONLY:

Initial visit _____ Release visit _____ %reduced _____
BMI _____ Neck _____ Waist _____ ESS _____ %reduced _____

AHI Beg _____ End _____ Prevx dx by _____
ODI Beg _____ End _____ Prevx dx date _____

CPAP intolerance due to _____ Reports sent _____ CB _____ Initial hst _____ Final hst
_____ Appliance Type _____ Del Date _____

Please circle all symptoms that you have experienced.



Signs And Symptoms Of TMJ

Your bite can be a factor in many types of pain or functional problems because of the inter-relationship of the overall musculoskeletal system.

Do You Suffer From Any Of These?

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Clenching Or Grinding |
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Jaw Joint Noise Or Clicking | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Limited mouth Opening | <input type="checkbox"/> Chewing Difficulties |
| <input type="checkbox"/> Ear Congestion | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Postural Problems |
| <input type="checkbox"/> Ringing In The Ears | <input type="checkbox"/> Tingling Of The Fingertips |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Hot & Cold Sensitivity Of Teeth |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Nervousness Or Insomnia |
| <input type="checkbox"/> Have You Ever Been In An Automobile Accident? | |

Financial Policy: Illinois Institute of Dental Sleep Medicine

It is the goal and commitment of Dr. Willey and his staff to always provide you with the highest level of care and expertise that we can offer. We are committed to your successful treatment and look forward to a rewarding relationship with you for years to come. In this spirit, we would like to avoid possible miscommunications that could arise regarding your account by outlining the following policies:

1. PAYMENT IS DUE AT THE TIME OF SERVICE.

We accept Cash, Checks, Credit and Debit Cards. *NSF checks will cost the patient appropriate additional fees.* **Initial** _____

2. FINANCING IS AVAILABLE UPON APPROVAL. When work is needed now and low monthly payments would be more convenient, inquire about how we can assist you with low interest and interest free financing. **Initial** _____

3. IF YOU HAVE INSURANCE, WE ARE HAPPY TO SUBMIT CLAIMS TO MOST CARRIERS.
Payment for deductibles and out of pocket expenses are estimated and due at the time of service.

- A. We can only *ESTIMATE* what your insurance will cover. Therefore, the account holder is responsible for any out of pocket expenses at the time of service and all unpaid balances after insurance has either paid their portion, or determined otherwise.
- B. Any balance remaining after insurance is complete, it will be due *within 30 days*. Likewise, if an insurance company pays more than estimated, we will refund the excess paid by you or apply it to a current balance due on your account. You may also leave it on account for future use if you so desire.
- C. In the event that the insurance carrier makes an overpayment error, we will refund payment to them.
- D. The patient is responsible to inform our office of any changes regarding their insurance provider or job status that might affect coverage or claim filing.
- E. Most insurance companies require the insured's *social security and date of birth*. If you do not wish to provide this information, we will be unable to file claims on your behalf. Therefore, payment in full will be due at the time of service.
- F. Signature below will be used as *Signature on File* for claims submission. It may also be used for Credit Application and Debit/Credit Card payments initiated by the account holder via phone.

Initial _____

3. OUTSTANDING BALANCES ARE DUE WITHIN 30 DAYS OF THE STATEMENT DATE.

Initial _____

4. TO AVOID BILLING FEES AND MONTHLY FINANCE CHARGES...

Please call our office promptly so we can facilitate a resolution to any/all of your concerns.

Initial _____

5. 24 HOURS NOTICE IS REQUIRED TO CANCEL OR RESCHEDULE AN APPOINTMENT.

A \$50.00, non-refundable, Missed Appointment Fee will be Charged. We hope to never have to charge this fee. We realize that emergencies may happen and will give proper consideration. **Initial** _____

I understand that in signing this form I take full responsibility for all fees incurred at Illinois Institute of Dental Sleep Medicine. In addition, I am responsible for collection and attorney fees should the account be turned over to collections.

Patient Name _____
(or Guardian if patient is a minor)

Date _____

IL. Institute of Dental Sleep Medicine

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement

officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Regional Manager

Tyler Willey
11825 N. State Route 40
Dunlap, IL 61525
Ph #: 309-243-7702

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

