Patient Registration

Today's Date ________________

Patient Information

First Name ______________________ Last Name ____________________ M.I. _____

Street Address ____

City, State, Zip ____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date _____________ Soc Sec # _____________ Driver's License # _____________

Email ______________________________ Spouse Name ______________________

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time ☐

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 ☐ Self ☐ Spouse

Insurance ID No. __________________ ☐ Child ☐ Other

Insured Soc Sec No. ____________________ Insured Birth Date __________________

Employer Name ______________________ Driver's License # __________________

Insured Address and Phone Number if different than patient

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 ☐ Self ☐ Spouse

Insurance ID No. __________________ ☐ Child ☐ Other

Insured Soc Sec No. ____________________ Insured Birth Date __________________

Employer Name ______________________ Driver's License # __________________

Insured Address and Phone Number if different than patient

Street Address ____

City, State, Zip ____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

Medical History Questionnaire

OFFICE USE
Patient ID: __________

NAME: ______________________________________
First   Middle Initital   Last

TODAY'S DATE ____________________

DATE OF BIRTH: ______________

This questionnaire was designed to provide important facts regardng 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 CAUSE AN ALLERGIC REACTION:

Y	N	Substance	Y	N	Substance	Y	N	Substance
☐	☐	Antibiotics	☐	☐	Latex	☐	☐	Sedatives
☐	☐	Aspirin	☐	☐	Local anesthetics	☐	☐	Sleeping pills
☐	☐	Barbiturates	☐	☐	Metals	☐	☐	Sulfa drugs
☐	☐	Codeine	☐	☐	Penicillin			
☐	☐	Iodine	☐	☐	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
Acid reflux	☐	☐	☐	
Adenoids Removed	☐	☐	☐	
Anemia	☐	☐	☐	
Arteriosclerosis	☐	☐	☐	
Arthritis	☐	☐	☐	
Asthma	☐	☐	☐	
Autoimmune disorder	☐	☐	☐	
Bleeding easily	☐	☐	☐	
Blood pressure - High	☐	☐	☐	
Blood pressure - Low	☐	☐	☐	
Bruising easily	☐	☐	☐	
Cancer	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Chronic cough	☐	☐	☐	
Chronic fatigue	☐	☐	☐	
Chronic pain	☐	☐	☐	
Cold hands and feet	☐	☐	☐	
COPD	☐	☐	☐	
Depression	☐	☐	☐	
Diabetes	☐	☐	☐	
Difficulty concentrating	☐	☐	☐	

Medical condition	Never	Current	Past	If past, enter date
Insomnia	☐	☐	☐	
Intestinal disorders	☐	☐	☐	
Jaw joint surgery	☐	☐	☐	
Kidney problems	☐	☐	☐	
Liver disease	☐	☐	☐	
Low energy	☐	☐	☐	
Meniere's disease	☐	☐	☐	
Menstrual cramps	☐	☐	☐	
Multiple sclerosis	☐	☐	☐	
Muscle aches	☐	☐	☐	
Muscle shaking (tremors)	☐	☐	☐	
Muscle spasms or cramps	☐	☐	☐	
Muscular dystrophy	☐	☐	☐	
Nasal allergies	☐	☐	☐	
Needing extra pillows to help breathing at night	☐	☐	☐	
Nervous system irritability	☐	☐	☐	
Nervousness	☐	☐	☐	
Neuralgia	☐	☐	☐	
Numbness of fingers	☐	☐	☐	
Osteoarthritis	☐	☐	☐	
Osteoporosis	☐	☐	☐	

Patient Signature ______________________ Date ______________

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

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

Other	Current	Past	If past, enter date		Current	Past	

ADDITIONAL MEDICAL HISTORY ITEMS:

	Never	Current	Past	If past, enter date
Recreational drugs				
HIV/AIDS				

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y	N	Operation	Y	N	Operation	Y	N	Operation
		Appendectomy			Hernia repair			sinus surgery
		Back			Knee Surgery			stent implant/heart
		Ear			Lung			Thyroid
		Gallbladder			Nasal			Tonsillectomy
		Heart			Periodontal			Uvulectomy

Other ______________________________

Patient Signature ______________________________ Date ____________________

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

__Yes __No Cancer
__Yes __No Heart disease
__Yes __No Diabetes
__Yes __No High blood pressure
__Yes __No Stroke
__Yes __No Sleep disorder
__Yes __No Obesity
__Yes __No Thyroid trouble
__Yes __No Father snores
__Yes __No Mother snores
__Yes __No Father has sleep apnea
__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

Patient Signature ______________________ Date ______________________

ILLINOIS INSTITUTE OF DENTAL
SleepMedicine
RODNEY E WILLEY, DDS, D'ACSDD

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

For Women Only:

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

For Office Use Only--

Enlarged Tonsils:
No: ________
Yes: ________
What Size? __________
BMI: _______
Blood Pressure: _______ Pulse: _______

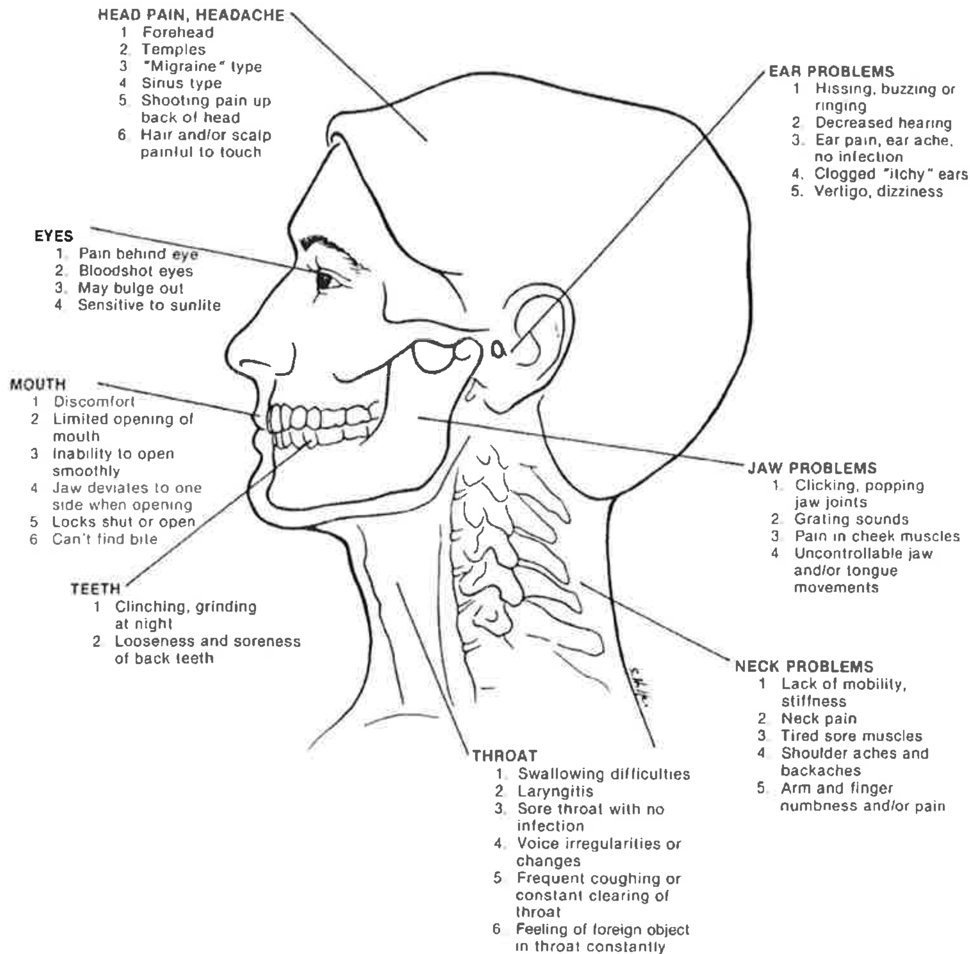
Mallampati Classification:
Class 1: ____
Class 2: ____
Class 3: ____
Class 4: ____

ILLINOIS INSTITUTE OF DENTAL
Sleep Medicine
RODNEY E. WILLEY, DDS

Patient Name:______________________

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?

❑ Headaches	❑ Clenching Or Grinding
❑ Jaw Joint Pain	❑ Facial Pain
❑ Jaw Joint Noise Or Clicking	❑ Sensitive Teeth
❑ Limited mouth Opening	❑ Chewing Difficulties
❑ Ear Congestion	❑ Neck Pain
❑ Dizziness	❑ Postural Problems
❑ Ringing In The Ears	❑ Tingling Of The Fingertips
❑ Difficulty Swallowing	❑ Hot & Cold Sensitivity Of Teeth
❑ Loose Teeth	❑ Nervousness Or Insomnia

❑ Have You Ever Been In An Automobile Accident?

Clinician Name ____________________
Address ____________________
____

TMJ SCALE™

This questionnaire is designed to help your doctor evaluate your problem. Please answer all questions as honestly as possible. Use a **dark #2 lead pencil**. Mark answers clearly, erasing completely any changes. Make no marks outside answer spaces. **Do not skip any questions**, even if you are not absolutely sure. (Marking Example: [ ] [■])

Initials: ___ ___ ___ File No. (filled in by clinician) ___ ___ ___ ___ ___ ___

Today's Date ___/___/___ Age _____ Sex (mark one) [1] Male [2] Female

Marital Status (mark one) [1] Single [2] Married [3] Separated [4] Divorced [5] Widowed [6] Remarried

Ethnic/Racial Group (mark one) [1] Black [2] Hispanic [3] Oriental [4] White [5] Other

Number of School Years (mark one) [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20+]

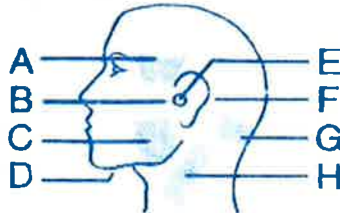
Problem Length (mark one) [1] None [2] Less Than 1 Month [3] 1-5 Months [4] 6-11 Months [5] 1-2 Years [6] 3-5 Years [7] 6-10 Years [8] 10+ Years

1. This question should only be answered if you have upper and lower front teeth or are wearing a replacement for them. Open your mouth as wide as possible and position your hand as shown in the diagram below. Place as many fingers as possible between your upper and lower front teeth. Now **mark one number** below indicating the **number of fingers.**

(mark one)

less than 1 finger	[0]
at least 1 finger	[1]
at least 2 fingers	[2]
at least 3 fingers	[3]
at least 4 fingers	[4]

For questions #2-8 below, locate each area on your face (except F) using the lettered diagram. Press each area firmly on both sides of your face. **Mark the number** that indicates the **maximum amount of pain** you feel.



no pain	0
slight pain	1
moderate pain	2
quite a bit of pain	3
extreme pain	4

(mark one)

2.	Pressing my temples (A on diagram)	[0] [1] [2] [3] [4]
3.	Pressing my jaw joints (B on diagram)	[0] [1] [2] [3] [4]
4.	Pressing my jaw muscles (C on diagram)	[0] [1] [2] [3] [4]
5.	Pressing the muscles under the sides of my jaw (D on diagram)	[0] [1] [2] [3] [4]
6.	Pressing in my ears (E on diagram)	[0] [1] [2] [3] [4]
7.	Pressing the back of my neck (G on diagram)	[0] [1] [2] [3] [4]
8.	Pressing the sides of my neck(H on diagram)	[0] [1] [2] [3] [4]

S.R. Levitt M.D., Ph.D., T.F. Lundeen, D.M.D., M.W. McKinney, Ph.D.
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Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

		(mark one)
9.	Just a light touch on my face causes shock-like pain.........	[0] [1] [2] [3] [4]
10.	My jaw must click or pop before I can open it wide.........	[0] [1] [2] [3] [4]
11.	My jaw opens all the way without any sideways movements.........	[0] [1] [2] [3] [4]
12.	My jaw locks open.........	[0] [1] [2] [3] [4]
13.	I have headaches which begin after seeing flashes of light or dark spots......	[0] [1] [2] [3] [4]
14.	My jaw moves easily.........	[0] [1] [2] [3] [4]
15.	I have health problems which haven't responded to treatment.........	[0] [1] [2] [3] [4]
16.	I have pain in my jaw joint(s) (B on the diagram).........	[0] [1] [2] [3] [4]
17.	My jaw tires easily when chewing.........	[0] [1] [2] [3] [4]
18.	I have headaches which are made worse by bright light.........	[0] [1] [2] [3] [4]
19.	It hurts my teeth when I bite.........	[0] [1] [2] [3] [4]
20.	I have muscle or joint pain in areas other than my head or neck.........	[0] [1] [2] [3] [4]
21.	I can move my jaw more to one side than the other.........	[0] [1] [2] [3] [4]
22.	I feel tense and worried.........	[0] [1] [2] [3] [4]
23.	I have drainage from my ear(s).........	[0] [1] [2] [3] [4]
24.	I feel sad and depressed.........	[0] [1] [2] [3] [4]
25.	I clench my teeth.........	[0] [1] [2] [3] [4]
26.	My bite feels comfortable.........	[0] [1] [2] [3] [4]
27.	I have jaw pain which gets worse the more I move my jaw.........	[0] [1] [2] [3] [4]
28.	It is difficult to find a comfortable position for my jaw.........	[0] [1] [2] [3] [4]
29.	I have pain in my ear(s) (E on diagram).........	[0] [1] [2] [3] [4]
30.	I have sinus problems.........	[0] [1] [2] [3] [4]
31.	When I bite down normally, my front teeth touch.........	[0] [1] [2] [3] [4]
32.	During my life, I've had many different painful disorders.........	[0] [1] [2] [3] [4]
33.	I have facial pain which comes on suddenly like electric shocks.........	[0] [1] [2] [3] [4]
34.	I can open my mouth as far as possible without pain.........	[0] [1] [2] [3] [4]
35.	I have pain in or behind my eye(s).........	[0] [1] [2] [3] [4]
36.	My jaw makes a grating or grinding noise when it opens and closes.........	[0] [1] [2] [3] [4]
37.	I think my bite is off.........	[0] [1] [2] [3] [4]
38.	I have pain which gets worse with stress or tension.........	[0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

		(mark one)
39.	My jaw clicks or pops when I chew	[0] [1] [2] [3] [4]
40.	I can bite down hard without pain in my jaw	[0] [1] [2] [3] [4]
41.	One painful problem is followed by another	[0] [1] [2] [3] [4]
42.	I have jaw pain which makes me feel sick and feverish	[0] [1] [2] [3] [4]
43.	I grind my teeth during the day	[0] [1] [2] [3] [4]
44.	I have numb areas on my face	[0] [1] [2] [3] [4]
45.	I use nerve pills, sleeping pills, or alcohol for relief	[0] [1] [2] [3] [4]
46.	I can move my jaw smoothly	[0] [1] [2] [3] [4]
47.	I can chew without bumping my teeth unexpectedly	[0] [1] [2] [3] [4]
48.	I have a feeling of pins and needles on my face	[0] [1] [2] [3] [4]
49.	I have pain in my jaw muscles (C on diagram)	[0] [1] [2] [3] [4]
50.	I have pain in the back of my neck (G on diagram)	[0] [1] [2] [3] [4]
51.	Over the years, I've been under a lot of stress	[0] [1] [2] [3] [4]
52.	My jaw twitches or jerks uncontrollably	[0] [1] [2] [3] [4]
53.	When I bite down normally, my back teeth touch	[0] [1] [2] [3] [4]
54.	The way my front teeth fit seems to be changing	[0] [1] [2] [3] [4]
55.	A light touch on one side of my face causes shock-like pain on the other	[0] [1] [2] [3] [4]
56.	I have a ringing in my ear(s)	[0] [1] [2] [3] [4]
57.	I have pain which gets worse with certain people or situations	[0] [1] [2] [3] [4]
58.	I have pain in the side(s) of my neck (H on diagram)	[0] [1] [2] [3] [4]
59.	I have a steady pain across my forehead	[0] [1] [2] [3] [4]
60.	I have many changing pains	[0] [1] [2] [3] [4]
61.	I feel angry	[0] [1] [2] [3] [4]
62.	Other people notice noise from my jaw when I chew	[0] [1] [2] [3] [4]
63.	I can chew food as well as I used to	[0] [1] [2] [3] [4]
64.	I have health problems which seem to be getting worse	[0] [1] [2] [3] [4]
65.	I have pain in the muscles under my jaw (D on diagram)	[0] [1] [2] [3] [4]
66.	I have pain in my temple(s) (A on diagram)	[0] [1] [2] [3] [4]
67.	I feel anxious	[0] [1] [2] [3] [4]
68.	I can open my mouth as wide as I used to	[0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

		(mark one)
69.	The way my back teeth fit seems to be changing	[0] [1] [2] [3] [4]
70.	I sleep well	[0] [1] [2] [3] [4]
71.	I have head or facial pain which gets worse when I bend over	[0] [1] [2] [3] [4]
72.	When I touch one side of my face, the other side gets numb	[0] [1] [2] [3] [4]
73.	My jaw gets stuck and won't open all the way	[0] [1] [2] [3] [4]
74.	The only real problems in my life are problems with my physical health	[0] [1] [2] [3] [4]
75.	I've had conflicting doctors' opinions about health problems	[0] [1] [2] [3] [4]
76.	I can move my jaw in any direction without pain	[0] [1] [2] [3] [4]
77.	I have facial pain which gets worse in cold weather	[0] [1] [2] [3] [4]
78.	I feel frustrated	[0] [1] [2] [3] [4]
79.	I have a stuffy nose	[0] [1] [2] [3] [4]
80.	Recently I've been under a lot of stress	[0] [1] [2] [3] [4]
81.	I have headaches which make me feel sick to my stomach	[0] [1] [2] [3] [4]
82.	I can take big bites of things like apples	[0] [1] [2] [3] [4]
83.	I have work or family pressures	[0] [1] [2] [3] [4]
84.	I have pain and stiffness in my finger joints	[0] [1] [2] [3] [4]
85.	My back teeth feel like they fit properly	[0] [1] [2] [3] [4]
86.	I believe I have an incurable problem in spite of reassurance by doctors	[0] [1] [2] [3] [4]
87.	In the morning my teeth are sore and my jaw is tired	[0] [1] [2] [3] [4]
88.	My ears feel blocked or stopped up	[0] [1] [2] [3] [4]
89.	I have many health problems	[0] [1] [2] [3] [4]
90.	My jaw moves just as far forward as it used to	[0] [1] [2] [3] [4]
91.	I have difficulty swallowing	[0] [1] [2] [3] [4]
92.	I have pain behind my ear(s) (F on diagram)	[0] [1] [2] [3] [4]
93.	I have facial pain when other joints are also sore	[0] [1] [2] [3] [4]
94.	I have nervous problems	[0] [1] [2] [3] [4]
95.	I have throbbing headaches	[0] [1] [2] [3] [4]
96.	I feel dizzy	[0] [1] [2] [3] [4]
97.	I consider myself to be a sickly person	[0] [1] [2] [3] [4]

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**___________

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

FOR OFFICE USE ONLY:

Initial visit_____ Release visit______
BMI___ Neck___ Waist___ ESS____

AHI Beg_____ End______
ODI Beg_____ End______

CPAP intolerance due to ___________________
____
____

Chief complaints______________________ %reduced____
______________________ %reduced____
______________________ %reduced____

Prev dx by ____
Prev dx date____

Reports sent ____CB ____Initial hst ____ Final hst

Appliance Type ___________________ Del Date____________

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 ______________________________ Date ____________
(or Guardian if patient is a minor)

April 14, 2003

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:

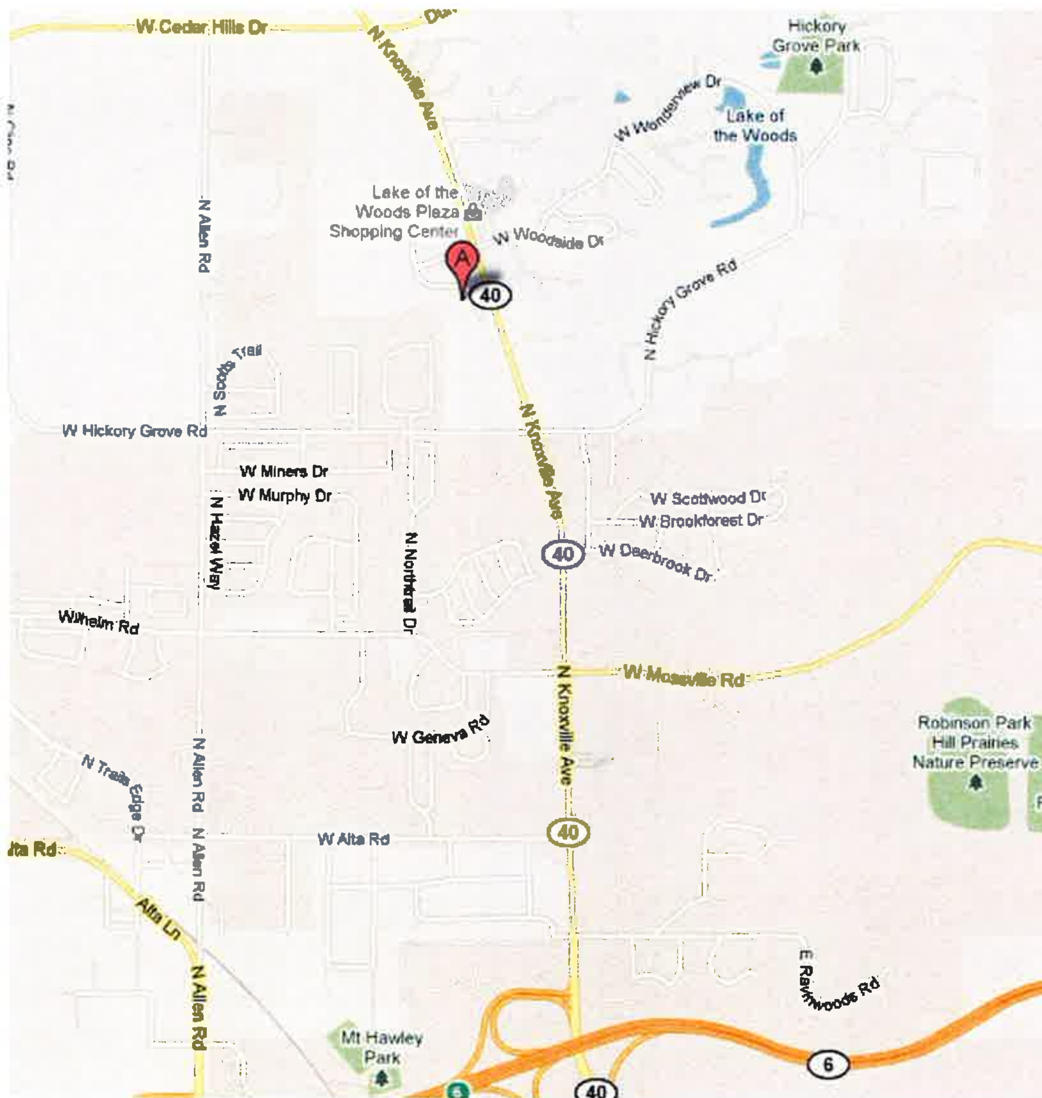
Regional Manager
Tyler Willey
11825 N. State Route 40
Dunlap, IL 61525
Ph #: 309-243-7702

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)

ILLINOIS INSTITUTE OF DENTAL

Sleep Medicine



Directions:

1. Knoxville Avenue is also known as Route 40
2. Look for the Stop Light marked W. Woodside Dr and Service Drive 2.
3. Turn toward Service Drive 2: to the left if coming from Peoria, to the right if coming from the north.
4. Landmark at Stop Light: Wheels of Time Museum.
5. Service Drive 2 comes to a “T” just after Wheels of Time Museum. Turn left.
6. You will approach the Maple Shade Professional Building from the rear.
7. Illinois Institute of Dental Sleep Medicine is on the first floor of the Maple Shade Professional Building.
8. We are just to the right of the elevator/waterfall in the main entrance area.

11825 N. State Route 40, Suite 100, Dunlap, IL 61525
Phone: 309-243-8980 Fax: 309-243-8983