345 East Main St. Tuckerton, NJ 08087 • Atlanticsleepsolutions@gmail.com • 609-993-2200 • Fax 609-294-4770

NEW PATIENT QUESTIONNAIRE

Date:

Patient Name: Date of Birth:

Address:

City/State: Zip:

Home Phone: Mobile:

Email: Social Security Number:

Gender: Height: Weight:

INSURANCE:

Name of Medical Insurance:

Member ID #: Group #:

Do you have secondary insurance?

If Yes, Insurance Name:

MEDICAL:

Primary Care Physician: Phone:

Dental Provider: Last Visit:

Specialist Care: Phone:

How Did You Hear About Us ?

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HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Obstructive Sleep Apnea	☐ Yes	☐ No
Loud Snoring	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Depression	☐ Yes	☐ No
COPD	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No

Do you have any Allergies? ☐ If Yes: ☐

Do you have any other Medical Conditions: ☐

Please list medications or supplements your taking. ☐

EPWORTH SLEEPINESS QUESTIONNAIRE

0=never doze 1=Slight Chance 2=Moderate Chance 3=High Chance

Sitting and reading	☐	As a passenger in a car while moving	☐
Sitting quietly in a public place	☐	In a car stopped in traffic for a few minutes	☐
Watching TV	☐	Lying down to rest in the afternoon	☐
Sitting quietly after lunch w/o alcohol	☐	Sitting and talking to someone	☐

TOTAL SCORE 0

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PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family members, friends, co-workers, and medical offices may ask questions about my possible sleep apnea treatment in person or over the telephone. I also understand it is a breach of physician/patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form, I am designating the parties below to be able to discuss any treatments with Atlantic Sleep Solutions.

I understand this form will be updated every calendar year. If I decide to make any changes regarding the release of information to any of the listed people, it is my responsibility to inform Atlantic Sleep Solutions in writing of my decision.

In accordance with the above, I (print name) _____

Authorize Atlantic Steep Solutions to discuss with and release my medical information to the following individuals and/or offices.

_____

_____

_____

_____

I authorize Atlantic Sleep Solutions to leave information regarding my care by:
(Check (X) all that apply)

Telephone (voicemail)	Email	Fax	Text
☐	☐	☐	☐

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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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 fees or 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 of 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 : William DeMarco DMD, 345 East Main St, Tuckerton, NJ 08087

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME:

PATIENT SIGNATURE:

DATE:

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HIPAA NOTICE OF PRIVACY PRACTICES AND OFFICE POLICY

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 and sign the last page. A copy of this form is available upon request.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care options (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services, including information related to sexually transmitted diseases and HIV.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to another doctor or DME company. For example, your protected health information may be provided to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

PROVIDER: William DeMarco DMD, 345 East Main St, Tuckerton, NJ 08087

INITIAL:

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Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for any test or appliance that requires your relevant protected health information to be disclosed to the health plan to obtain approval for proper treatment. I am responsible for the payment of all services rendered on my behalf. I have been informed that payment is due at the time of service. Insurance will be calculated into your total estimated treatment plan. We accept most major credit cards, cash, and checks. We offer an extended payment plan through CareCredit with interest-free financing upon credit approval.

Your Rights: You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information to not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME:

PATIENT SIGNATURE:

DATE:

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INFORMED CONSENT FOR THE TREATMENT OF OBSTRUCTIVE SLEEP APNEA AND SLEEP DISORDERED BREATHING

Obstructive sleep apnea (OSA) is a medical condition with a dental treatment. For OSA to be treated by a dentist, a diagnosis of OSA must be made by a physician trained in the field of Sleep Medicine. If you have not been diagnosed with OSA by your physician, please understand that we will not proceed with treatment without an overnight sleep study in a sleep lab and a diagnosis of OSA by the attending sleep physician. We will work in collaboration with your physician to achieve the best results possible for the treatment of your sleep apnea.

SUCCESSFUL TREATMENT: Oral appliance therapy is a very effective treatment. However, no therapy works 100% of the time. The mandibular advancement device (MAD) works by moving the jaw and tongue forward at night, which acts to keep the airway open. As with any medical therapy, successful treatment of OSA using dental appliances cannot be guaranteed. Success depends on many things. The most important component of success is patient compliance. By signing this document, you hereby agree to follow our instructions in detail. Failure to do so may result in a poor clinical outcome.

COMPLICATIONS OF TREATMENT: OSA is an unusual disease because it has been associated with many comorbid medical conditions. As a result of OSA, or as a complication of OSA treatment, patients may develop any or all of the following temporary or permanent co-morbid diseases: coronary artery disease; high blood pressure; diabetes; cerebrovascular disease; stroke; heart problems; heart attack; atrial fibrillation, depression, mood disorders, sexual dysfunction, weight gain, obesity; excessive daytime sleepiness; increased work related and traffic related accidents; and death.

Dental Issues: A number of temporary or permanent dental issues can develop as a result of long term treatment of OSA with a mandibular advancement device (MAD), including but not limited to: jaw joint pain; moderate or severe TMJ dysfunction; headaches; backaches; neck aches; pain on chewing; facial pain; popping and noise in the jaw; sore teeth; dental decay, gum (periodontal) disease, gingivitis; worsening of periodontal pockets; tooth loss; loosening of teeth, dry mouth or excess saliva; fracturing or loosening of dental fillings, crowns or bridges; short term or long term bite changes; spacing or shifting of teeth; tilting of teeth; profile changes; lessening of overbite or over jet; dental infection; infection of the gums; difficulty chewing; oral cysts, oral tumors, oral cancer, and death.

FINAL SLEEP STUDY AND EVALUATION: After your appliance is placed, it will be adjusted by us to achieve the best results possible. When your apnea symptoms have improved, and we are satisfied with the results of the adjustments, you will be referred back to your physician for post-treatment evaluation and a posttreatment sleep study. This evaluation is to ensure that your apnea is adequately controlled by the MAD and that no further adjustments or other treatment is needed. Your treatment must be confirmed by an in-lab sleep study and evaluated by your physician after we complete our adjustments.

INITIAL:

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INFORMED CONSENT FOR THE TREATMENT OF OBSTRUCTIVE SLEEP APNEA AND SLEEP DISORDERED BREATHING

Follow-up appointments are required with our office on a 6-month or yearly basis to check the effectiveness of your appliance and the success of your OSA treatment. Failure to maintain these follow-up appointments will constitute a lack of compliance with our office's treatment plan. Any decision on your part to forego follow-up appointments places your health at risk and increases the probability of complications and treatment failure.

Additionally, recall appointments should be kept with your general dentist on a three-month schedule for the first year that you wear a MAD to evaluate your dental hygiene, gums, and check for decay. By signing this agreement, you agree to schedule the recommended recall appointments.

ALTERNATIVE TREATMENTS: By signing this consent form, you acknowledge that you have been made aware of reasonable alternatives to MAD therapy for obstructive sleep apnea, including, but not limited to: tracheotomy; CPAP; oral or pharyngeal surgery; positional sleep therapy; weight loss and exercise. Additionally, you are aware that more than one treatment may be necessary for the best results.

WHEREFORE: I give my consent for the treatment of my OSA using a mandibular advancement device (MAD). I agree and consent to allow qualified members of this office to examine my mouth, teeth, jaws, gums, and associated structures. I give consent for the taking of X-rays, photos, impressions, and any other procedures necessary for the treatment of my OSA. I, also, give consent for a home sleep study, if necessary, for the adjustment of my appliance. I consent for the contents of my record to be shared with my physician and insurance company.

I affirm that I have read this document and have been given adequate information regarding the treatment of my condition to give my informed consent. I understand the proposed treatment of my OSA using MAD therapy, and I have been given the opportunity to ask questions:

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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AFFIDAVIT FOR INTOLERANCE TO CPAP

I, _____ make this statement and General Affidavit upon affirmation of belief and personal knowledge that the following matters are correct to the best of my knowledge.

I have been prescribed the nasal CPAP to manage my sleep-related breathing disorder (apnea), and it has been advised that it is the GOLD STANDARD OF CHOICE for treatment of Obstructive Sleep Apnea. However, I find it is or will be intolerable to use on a regular basis due to the following reason(s):

- ☐ Mask leaks
- ☐ Mask is uncomfortable/device is uncomfortable
- ☐ Straps/headgear cause discomfort
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs sleep and/or bed partner's sleep
- ☐ Movement is restricted during sleep
- ☐ Pressure on the upper tip causes toothrelated problems
- ☐ Claustrophobia
- ☐ Unable to breathe through the nose
- ☐ Other _____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That method of treatment is a Custom Oral Appliance, as prescribed to me by:

Dr. _____

By signing this consent form, you acknowledge that you have been made aware of reasonable alternatives to therapy for obstructive sleep apnea, including, but not limited to, tracheotomy, CPAP, oral or pharyngeal surgery, positional sleep therapy, weight loss, and exercise. Additionally, you are aware that more than one treatment may be necessary for the best results.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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AFFIDAVIT OF CPAP REFUSAL

I have NOT attempted and REFUSE to use CPAP (Continuous Positive Air Pressure) to manage my Obstructive Sleep Apnea (OSA)-related breathing disorder and find it intolerable to use regularly for the following reasons:

Check (x) all that apply:

☐ In accordance with the clinical guidelines of the American Academy of Dental Sleep Medicine, I elect to treat my mild-moderate Obstructive Sleep Apnea with Oral Appliance Therapy as first-line therapy without prior trial of CPAP.

☐ I believe I will be unable to tolerate CPAP therapy due to documented claustrophobia.

☐ I believe I will be unable to tolerate CPAP therapy due to frequent nasal/sinus infections or chronic congestion, which impedes my ability to breathe through my nose.

☐ I believe I will be unable to tolerate CPAP therapy due to skin irritation, sensitivity, or allergies related to the CPAP mask material.

Other: _____

I understand that I am refusing CPAP therapy, a standard treatment option for OSA, and elect to proceed with Oral Appliance Therapy as first-line therapy in accordance with my treating physician's recommendations.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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GENERAL RELEASE OF LIABILITY & ASSUMPTION OF RISK FOR OBSTRUCTIVE SLEEP APNEA AND SLEEP DISORDERED BREATHING

I, _____ understand that due to the nature of sleep medicine, failure to comply with the treatment can result in severe physical and social issues, including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; hypertension; excessive sleepiness; and increased mortality.

As this office cannot ensure success of any type of therapy and cannot guarantee that any patient will comply with the treatment for sleep apnea, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I might sustain as a result of my treatment for sleep apnea or any failure on my part to comply with treatment.

Therefore, I release this office and its affiliates from any and all liability associated with my treatment and I personally assume all risks associated with my care, including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; increased work place accidents; hypertension; excessive sleepiness; TMJ disease; periodontal disease and increased mortality.

I hereby agree to indemnify and hold this office and its affiliates harmless for any issues or damages that might result from my sleep apnea treatment.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS NAME: _____

WITNESS SIGNATURE: _____ **DATE:** _____

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NON-DENTIST OF RECORD RELEASE FORM

I am seeking treatment with a sleep orthotic appliance only. I understand that I am not a dental patient-of-record with **William DeMarco DMD.**

The importance of regular dental care has been explained to me, and I understand that **William DeMarco DMD,** will not be responsible for providing my preventative or emergency dental needs. At this time, I choose to have my routine and necessary dental care completed in another office.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT:

PRINT NAME:

PATIENT SIGNATURE:

DATE: