



Snoring and Sleep Apnea Form

*Required Fields

Epworth Sleepiness Scale

Patient's Name

Date of Birth

Today's Date

Please answer the following questions below to determine if you might be at risk for a sleep breathing disorder.

**0 = no chance of dozing,
2 = moderate chance of dozing,**

**1 = slight chance of dozing,
3 = high chance of dozing**

	1	2	3
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place or a meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when situations permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score:	<input type="text"/>		

Note: If you have a score above 6 or you do not wake feeling refreshed and rested or you or your sleep partner identify that you choke or stop breathing in your sleep, you should be evaluated by a trained professional.

Signature

Date

STOP-BANG Questionnaire

	Yes	No
Do you snore loudly (loud enough to be heard through closed doors at night)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel tired, fatigued, or Sleepy during the daytime?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone observed you stop breathing or choking/gasping during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or are being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Body Mass Index (BMI) more than 35 kg/m ² ? The BMI is calculated by dividing the person's weight in kilograms by the square of height in meters (kg/m ²) or by dividing the person's weight in pounds by the square of height in inches. The internet has a few ways to calculate the BMI.	<input type="checkbox"/>	<input type="checkbox"/>
Is your age older 50 years?	<input type="checkbox"/>	<input type="checkbox"/>
Is your neck size large? (Male > 17" (43cm), Female > 16" (41cm))	<input type="checkbox"/>	<input type="checkbox"/>
Is your gender Male?	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Name

Affidavit for Intolerance or Non-Compliance to CPAP Machine

I have attempted or do not wish to use CPAP (Continuous Positive Air Pressure) to manage my sleeprelated breathing disorder (OSA Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- The mask air leaks
- The mask does not fit my face properly
- The straps and headgear cause facial discomfort
- The presence of the CPAP machine disturbs or interrupts my sleep
- The CPAP noise disturbs my sleep or my bed partner's sleep
- The CPAP restricts my movements during sleep
- The CPAP does not seem to be effective in helping my breathing during sleep
- The CPAP presses on my upper lip causing tooth-related problems
- I have a latex allergy
- I have a claustrophobic feeling when things are close to my face
- I experience an unconscious need to remove the CPAP apparatus at night
- Other:

If other, please explain:

I wish to have Oral Appliance Therapy using a custom made and fitted Mandibular Advancement Device to manage my Obstructive Sleep Apnea.

Signature

Date

Other Symptoms:

	Right	Left	Both Sides
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain when Chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
or Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Soreness in TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/Grating in TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Jaw Opening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful/Burning Tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth/Gum Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Right	Left	Both Sides
Jaw Locks Open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Like Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fullness in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postural Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in/Behind Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neckache or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Neck Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Significant Medical History

Are you currently or have taken in the past any medication for osteopenia or osteoporosis such as Prolia, Reclast, Fosamax, Fonteo, Evista, or others?

Yes No

List your current medications, their doses, and the reason you are taking them

Have you had any surgery? Yes No

If Yes, Please list them and their dates:

Have you been diagnosed with any medical issues? Yes No

If Yes, Please list them and the date of their diagnosis:

Have you had manipulative therapy such as chiropractic spine alignment, physical therapy, or osteopathic manipulation? Yes No

If Yes, Please list them and the date of their diagnosis:

Have you had psychological or psychiatric treatment? Yes No

If Yes, Please explain the reason and type of treatment (such as counseling or medications):

Are you experiencing work, family, or environmental stress? Yes No

If Yes, Please explain:

Do you have any diet problems such as dietary restrictions, food allergies, dieting, eating a soft diet? Yes No

Do you have any sleep difficulty or disorder such as difficulty falling or staying asleep, frequent sleep interruption, snoring, gasping for air, nightmares, vivid dreams, frequent urination, unrefreshing sleep, or other sleep problems? Yes No

List of doctors that you would like us to send a report to

Doctor's Name	Phone Number	Address

Office Policy Concerning Insurance and Third-Party Payment for Service

I understand, accept, and agree that payment for services is required at the time of service. In the event payment for services, when a delay is agreed upon by this office, is not made within 30 days for any reasons, then interest at the prevailing legal rate plus a service charge may be added to the past due balance. If collection or legal services are required to obtain payment of the billed amount, I further agree to pay for all legal fees and costs reasonably incurred in connection in addition to that. Interest not paid when due shall be added to and become part of the principle.

When an insurance policy is initially accepted by this office, I further understand, this office acceptance of insurance is in good faith and based on insurance's validity to pay for any services and that I reviewed it and am aware of its coverage. Moreover, I understand, accept, and agree to the following.

Dental, medical, or personal injury insurance, workman's compensation, Medicare, or any other third party may vary in their coverage and exclusions. This office does not guarantee coverage of any procedure by any insurance carriers even when the coverage is claimed acceptable orally or in writing by the insurance personnel. Some policies may require limited procedures, limited visits, a waiting period, and partial or no coverage.

This office cannot commence diagnosis or treatment contingent upon payment by the dental, medical insurance company, Medicare, workman's compensation, or any other party. This office does not diagnose or treat me based on the insurance coverage but instead based on what is necessary for my health and well-being. I do authorize this office to perform whatever essential for my or my dependent's health without insurance restrictions.

I understand that the doctors and their staff are concerned about my dental, medical, and general health and should not modify or change my or my child's treatment plan according to the insurance coverage. This office is not responsible for insurance rules, guidelines, errors, or omissions. Some of the procedures may be covered, but many others may not. When insurance refuses or rejects the payment, this does not mean that the treatment was not necessary. It just means that the insurance does not approve this stage of the disease or disorder for coverage. I hold this office, its doctors, and staff harmless from any action by the insurance company.

The following procedures received no or unfavorable compensation by some insurance companies, and my insurance company may be acting the same:

- Composite (white) restorations (fillings).
- Cosmetic treatment of anterior teeth.
- Treatment of mild or moderate periodontal (gum) diseases
- Replacement of old crowns or bridges
- Replacement of missing teeth with bridges or partial dentures
- Diagnosis and treatment of jaw joint (TMJ disorders) with physical medicine, Splint injections, or others.
- Diagnosis and management of bruxism (clenching jaws or grinding teeth)
- Diagnosis and management of snoring or mild sleep apnea

In case the insurance or third party failure to pay for any reason within 30 days, I will be responsible for paying for all the services rendered. I realized that the insurance contract is between me (my spouse or parent and the insurance company). Any problem in coverage will be my complete responsibility, and I am responsible for all payments.

This office does not accept Medicare assignments. We have "opted out" of the Medicare Program. Recent legislation per section 603 of public law 108-173 allows private contracts with Medicare beneficiaries. Furthermore, Medicare does not cover procedures such as TMJ, craniofacial pain, sleep apnea appliances, or night/mouth guards. Moreover, Medicare does not cover dental services.

Medicare beneficiaries must sign their acknowledgment that reimbursement for their treatment is most likely to be denied.

I now certify that this form has been explained to me, I have read it over, or had it read to me, that the blank spaces have been filled and that I understand, accept, and agree to its content. This office will only file an insurance claim one time as a courtesy. Additional filing will incur other reasonable costs that will be determined based on the needed amount of work.

*Patient First Name:**

*Patient Middle Name:**

*Patient Last Name:**

*Signature:**

Relation to Patient:

*Date:**

Medicare Opt-Out Private Contract

This contract between Dr. Reda A. Abdel-Fattah and Dr. Mervat Alattar ("Dentist") or "Dental TMJ Sleep Apnea" and the Medicare Beneficiary, referred to in this contract as ("Patient"), allows Dentist to provide treatment to Patient without being subject to Medicare limits.

To do so, the law requires Dentists to "opt out" of Medicare and that no Medicare claim be filed for the treatment of Patients by Dentists. Dentist represents that Dentist (are): excluded from participation under the Medicare program under S1128, 1156 or 1892 of the Social Security Act; in addition, Patient and Dentist agreed that Patient is not now facing an emergency or urgent health care situation.

Accepted and Agreed By signing this contract, the Patient does the following:

- (i) Agrees not to submit a Medicare claim (or to request the Dentists submit a claim). For services or items supplied by Dentist, even if they are otherwise covered under Medicare;
- (ii) Agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentists and understands that no reimbursement will be provided under Medicare for those services or items; in particular, the Patient will pay for such services at the Dentists usual rate (or another agreed to upon rate), following Dentists payment policies;
- (iii) Acknowledges that Medicare limits do not apply to amounts that Dentists may charge for such services or items;
- (iv) Acknowledges that Medicare plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract because payment is not made under Medicare; and
- (v) Acknowledges that the Patient has the right to have such services or items provided by other Dentists or practitioners for whom payment would be made under Medicare. (Patient is not required to enter into private contracts that apply to other Medicare-covered services furnished by other Dentists who have not opted out.)
- (vi) This contract shall remain in force and effect from the date it is signed by the Patient until the end of the term of the Dentists' current opt-out period. The expected date of the Dentists opt-out is two years from the date of signature or if the Dentists decide to participate.

*Patient First Name:**

*Patient Middle Name:**

*Patient Last Name:**

*Signature:**

Relation to Patient:

*Date:**

Workman's Compensation, Medicare, Medicaid, No-Fault Accident, and Third-Party Insurance Policy

I understand and accept the office of Drs. Abdel-Fattah and Alattar (Dental TMJ Sleep Apnea) do not accept Workman's Compensation, Medicare, Medicaid, no-fault accident insurance payment, or any assignment from any third party. I am fully responsible for all fees incurred in diagnosis, prevention, treatment, and other administrative services. I understand that my insurance policy may or may not cover any or all of these services. This office does not claim or accept any responsibility for the insurance companies action.

*Patient or Patient's Legal Representative Signature:**

*Date:**

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment such as referring health care providers, laboratories, transcription services, or others);
- Obtaining payment from third-party payers (e.g., my insurance company, collection agency);
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

Your name: * _____ Relation to the Patient : * _____

Signature: * _____ Date: * _____

For the safety of our team, other patients, and yourself, please be truthful and candid in your answers.

If you have been exposed to a communicable disease, you may spread the disease to the Dentist, dental staff, or other patients/parents in practice. Therefore, before each appointment, we will be asking the following questions to reduce the chances of transmission:

First Name: * _____ Last Name: _____

Have you, your child, or others accompanying you to today's appointment tested positive for or been diagnosed as having COVID-19 or any other contagious disease? Yes No

If Yes, when?

Have you, or anyone you have come into contact with, traveled out of state or outside of the country within the last 21 days? Yes No

If Yes, where?

Have you or anyone close to you experienced flu-like symptoms within the past 14 - 21 days, such as:

	Yes	No
Cough (wet or dry)	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Body Aches	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting/Stomachache	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Recent Loss of Taste or Smell	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Pain, Pressure, or Tightness in the Chest	<input type="checkbox"/>	<input type="checkbox"/>

I UNDERSTAND THAT I AM OBLIGATED TO ANSWER THESE QUESTIONS TRUTHFULLY. I ALSO UNDERSTAND IF THE ANSWER TO ANY OF THESE QUESTIONS IS YES, I MAY BE ASKED TO RESCHEDULE TODAY'S DENTAL APPOINTMENT.

The staff of this office is taking the possible measures to avoid transmission of this virus but no guarantee of anyone's safety. I have been aware that social distancing of at least six (6) feet to reduce the transmission of the virus is impossible with my Dental/TMJ/Facial Pain/ Sleep Apnea or any other treatment completed during the COVID-19 time.

Signature: * _____

Date: * _____