Shore Dental SleepCare
Sleep Apnea Specialists

Dr. John M. Young Jr., DDS
Board Certified in Dental Sleep Medicine
Diplomate American Clinical Sleep Disorders Discipline

We would like to take this opportunity to thank you for trusting us and selecting us for your sleep apnea and dental needs. We appreciate your trust in us and assure you that we will address any concerns to your satisfaction.

Our caring staff believes in providing a comfortable atmosphere during treatment. We offer appointment times to fit most lifestyles and strive to provide each of our patients with personal attention and excellent results!

On your first visit, Dr. Young will provide a full comprehensive clinical examination including x-rays, if needed, and address your personal concerns regarding the best treatment for you. We work with most medical insurances, and will look into each individual plan to explain how your plans coverage works before treatment is started.

New patient forms including medical history and consent forms are enclosed. Please bring these completed forms with you to your appointment, along with all insurance cards and a form of ID.

We look forward to meeting you on _____.

Our office is located at *990 Cedar Bridge Avenue, Suite B15 in Brick, New Jersey*. Feel free to contact us at 732-477-1600 if we can be of further assistance.

Regards,

Shore Dental SleepCare

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Sleep Apnea Specialists

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SLEEP SCREENING QUESTIONNARIE

Patient Information

Name:_____ MALE FEMALE

Date Of Birth:_____ Height:_____ Weight:_____

Address:_____

City/State/Zip:_____

Primary Phone:_____ Secondary Phone:_____

E-Mail:_____

Responsible Party:_____

-Employed By:_____

Address:_____

-Primary Care Physician:_____Phone#:_____

Address:_____

-Dentist:_____Phone#:_____

Address:_____

-Other Health Care Providers Seen In Last 9 Months:_____

-Insurance Provider:_____ -Secondary Insurance:_____

Member ID:_____ Member ID:_____

Group Number:_____ Group Number:_____

Plan Name:_____ Plan Name:_____

Referred By:_____

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

__Frequent Heavy Snoring
__Which Affects Sleep Of Others
__I Have Been Told "I Stop Breathing" While Asleep
__Difficulty Falling Asleep
__Feeling Unrefreshed In The Morning
__Morning Hoarseness
__Daytime Drowsiness
__Jaw Pain
__Facial Pain
__Morning Headaches
__Swelling In Ankles/Feet
__Nocturnal Teeth Grinding
__Nighttime Choking Spells
__Jaw Clicking

Other:_____

Patient Signature:_____ **Date:**_____

Sleep Center Evaluation

Have you ever had a sleep study done at a Sleep Center? ☐ Yes ☐ No

If "Yes":

Sleep Center Name:_____

Location:_____

Date:_____

Referred By:_____

Other Therapy Attempts

What other therapies have you tried for breathing disorders?(weight-loss attempts, smoking cessation, surgeries, etc.)

_____

_____

_____

_____

Patient Signature:_____ Date:_____

Family History

Have any members of your family (blood kin) had:

Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Have any immediate family members been diagnosed or treated for a sleep disorder? ☐ Yes ☐ No

Social History

-Alcohol Consumption: How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐Once A Week ☐Several Days A Week ☐Daily ☐Occasionally

-Sedative Consumption: How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐Once A Week ☐Several Days A Week ☐Daily ☐Occasionally

-Caffeine Consumption: How often do you consume caffeine 2-3 hours before bedtime?

☐ Never ☐Once A Week ☐Several Days A Week ☐Daily ☐Occasionally

-Do you smoke? ☐ Yes ☐ No

If yes, please enter the approximate quantity daily:_____.

-Do you use chewing tobacco? ☐ Yes ☐ No

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentists and physicians. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all treatment regardless of insurance coverage.

Patient Signature:_____ **Date:**_____

Medical History

Please select/list any medications which have caused an allergic reaction:

___Antibiotics
___Aspirin
___Barbiturates
___Codeine
___Latex
___Local Anesthetics
___ Metals:_____
___ Penicillin
___ Plastic
___ Sedatives
___ Sleeping Pills
___ Sulfa Drugs
Other:_____
_____
_____
_____
_____
_____

Please list any medications that you are currently taking:

___ Antacids
___ Antibiotics
___ Anticoagulants
___ Anti Depressants
___ Anti-Inflammatory Drugs (non-steroid)
___ Barbiturates
___ Blood Thinners
___ Codeine
___ Cortisone
___ Diet Pills
___ Heart Medication
___ High Blood Pressure Medications
___ Insulin
___ Muscle Relaxants
___ Nerve Pills
___Pain Medication
___ Sleeping Pills
___ Sulfa Drugs
___ Tranquilizers
Other Medications:_____
_____
_____

Medical History

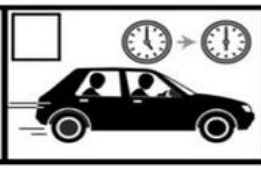
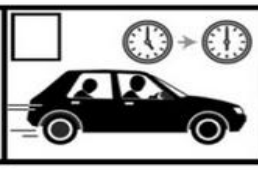
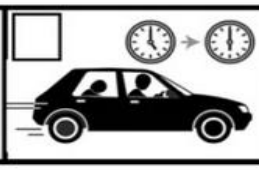
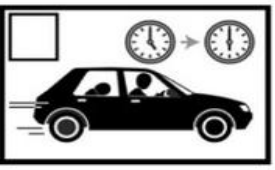
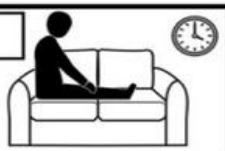
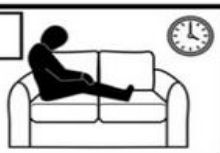
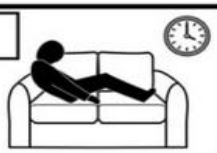
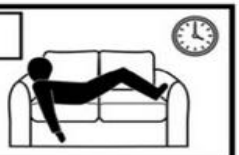
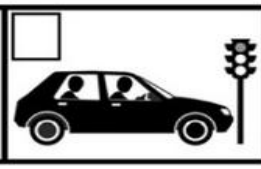
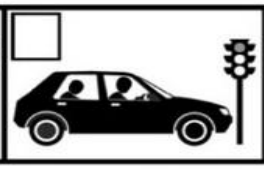
___Anemia
___Arteriosclerosis
___Asthma
___Autoimmune Disorder
___Bleeding Easily
___Chronic Sinus Problems
___Diabetes
___Dizziness
___Emphysema
___Fibromyalgia
___Frequent Sore Throat
___Gastroesophageal Reflux Disease (GERD)
___Hay Fever
___Heart Disorder
___Heart Murmur
___Heart Pounding or Beating Irregularly During The Night
___ Nighttime Sweating
___Heart Pacemaker
___Heart Value Replacement
___Heartburn or sour taste in mouth at night
___Hepatitis
___Immune System Disorder
___Injury to Face/Neck/Head/Teeth (circle please)
___Insomnia
___Irregular Heartbeat
___Jaw Joint Surgery
___Low Blood Pressure
___Memory Loss
___Migraines
___Morning Dry Mouth
___Muscle Spasms or Cramps
___Needing Extra Pillows To Help Breathing At Night
___Osteoarthritis
___Osteoporosis
___Poor Circulation
___Prior Orthodontic Treatment
___Recent Excessive Weight Gain
___Rheumatic Fever
___Shortness of Breath
___Swollen, Stiff, or Painful Joints
___Thyroid Problems
___Tonsillectomy
___Wisdom Teeth Extraction
Other:_____
_____
_____
_____
_____
_____
_____

Patient Signature:_____ **Date:**_____

Pictorial Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how they would affect you.

Use the following scale to choose the most appropriate number for each situation.

Situation ☑ *Please tick box*	0 No chance of dozing	1 Slight chance	2 Moderate chance	3 Definitely would doze
Sitting and reading	☐ 	☐ 	☐ 	☐ 
Watching TV	☐ 	☐ 	☐ 	☐ 
Sitting inactive in a public place (e.g. Theatre or a meeting)	☐ 	☐ 	☐ 	☐ 
As a passenger in a car for an hour without a break	☐ 	☐ 	☐ 	☐ 
Lying down to rest in the afternoon when circumstances permit	☐ 	☐ 	☐ 	☐ 
Sitting and talking to someone	☐ 	☐ 	☐ 	☐ 
Sitting quietly after lunch without alcohol	☐ 	☐ 	☐ 	☐ 
In a car, while stopped for a few minutes in traffic	☐ 	☐ 	☐ 	☐ 

total sleepiness score / 24

Berlin Questionnaire Sleep Evaluation

Please complete the following:

Height_____ Weight_____
Age_____ Male/Female

1. Do you snore:

☐Yes
☐No
☐I Don't Know

If you snore please answer #2-4, if not, proceed to question #5.

2. Your snoring is…

☐Slightly louder than breathing
☐As loud as talking
☐Louder than talking
☐Very loud, can be heard in adjacent rooms

3. How often do you snore?

☐Nearly every night
☐3-4 times a week
☐1-2 times a week
☐ 1-2 times a month
☐Occasionally

4. Has your snoring every disturbed the sleep of others?

☐Yes
☐No

5. Has anyone noticed that you stop breathing during your sleep?

☐ Yes, almost every night
☐ Yes, 3-4 times a week
☐ Yes, 1-2 times a week
☐ Yes, 1-2 times a month
☐ No

6. How often do you feel tired of fatigued after you sleep?

☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐1-2 times a month
☐ Never or rarely

7. During your wake time, do you feel tired, fatigued, or not up to par?

☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐1-2 times a month
☐ Never or rarely

8. Have you ever fallen asleep or nodded off while driving a vehicle?

☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐1-2 times a month
☐ Never or rarely

9. Do you have high blood pressure?

☐Yes
☐No

Signature:_____

Date:_____

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AFFIDAVIT FOR INTOLERANCE OR NON-COMPLIANCE TO CPAP

I, _____, have attempted or been recommended to use CPAP (Continuous Positive Air Pressure)to manage my sleep related breathing disorder, (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

Mask Leaks

An Inability To Get The Mask To Fit Properly

Discomfort Caused By The Straps And Headgear

Disturbed Or Interrupted Sleep Caused By The Presence Of The Device

Noise From The Device Disturbing Sleep Or Bed Partner's Sleep

CPAP Restricted Movements During Sleep

CPAP Does Not Seem To Be Effective

Pressure On The Upper Lip Causes Tooth Related Problems

Latex Allergy

Claustrophobic Associations

An Unconscious Need To Remove The CPAP Apparatus At Night

Other_____

Because of my intolerance/inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device.

Signature:_____ Date:_____

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Informed Consent For The Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder.
A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep- related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below.

Name:_____ **Date:**_____

Signature:_____

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Patient Release of Medical Records Form

_____ (_____) request and give my permission to release
(Patient Name) (Date of Birth)
my Polysomnogram and Titration Reports to:

Shore Dental SleepCare
990 Cedar Bridge Avenue, Suite B15
Brick, New Jersey 08723
Ph: 732-477-1600
Fx: 732-477-1490

_____ _____ _____-____-_____
Patient's Name Date of Birth Social Security Number

_____ _____
Patient Signature Date

Shore Dental SleepCare
Sleep Apnea Specialists

Dr. John M. Young Jr., DDS
Board Certified in Dental Sleep Medicine
Diplomate American Clinical Sleep Disorders Discipline

Effective date of notice: February 2012

NOTICE OF PRIVACY PRACTICES

John M. Young Jr., DDS
990 Cedar Bridge Avenue, Suite B15
Brick, New Jersey 08723
Phone: 732-477-1600
Fax: 732-477-1490

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

[We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale of information, any use of information for marketing or fundraising purposes, etc.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;

- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
-

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some

other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

----------tear here----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. John Young's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

Shore Dental SleepCare
Sleep Apnea Specialists

Dr. John M. Young Jr., DDS
Board Certified in Dental Sleep Medicine
Diplomate American Board of Dental Sleep Medicine

990 Cedar Bridge Ave, Suite B15 Ph: 732-477-1808
Brick, New Jersey 08723 Fx:732-477-1490
www.ShoreDentalSleepCare.com

Patient's Name:_____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. Medicare or your Private Insurance may not pay for items or services that are described below:
Custom Oral Appliance

Medicare or your Private Insurance may not pay for all or some of your health care costs. Your insurance only pays for covered items and services when their rules are met. The fact that they may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason that your doctor recommends it. Right now, in your case, your insurance may not pay for items and services listed below: **Custom Oral Appliance**

Because:

- Secondary deductible may not have been met
- AHI too low
- Need to try CPAP therapy first
- Open Workman's Comp case or No-Fault case
- Do not have benefits for this procedure

*The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you may have to pay for them yourself.

Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your insurance company will not pay.
- Ask us how much these items or services will cost you, in case you have to pay for them yourself or through other insurance.

PLEASE INITIAL THE OPTION YOU CHOOSE AND SIGN AND DATE AT THE BOTTOM

_____**Yes:** I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance company does pay, you will refund to me any payments I made to you that are due back to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.
_____**No**: I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance will not pay.

_____ _____
Signature Date

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare or Private Insurance, your health information on this form may be shared with Medicare or your Private Insurance. This information will be kept confidential by Medicare or your Private Insurance.