

## Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze

2 = Slight chance of dozing

3 = Moderate chance of dozing

4 = High chance of dozing

<b>Situation</b>	<b>Chance of Dozing</b>
Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for 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 stopping for a few minutes in traffic	_____
	<b>Total Score</b> _____

A score of 6 or greater indicates the possibility of sleep disordered breathing.

Today's Date \_\_\_\_\_  
 Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ F \_\_\_\_\_ M \_\_\_\_\_  
 Marital Status \_\_\_\_\_ SS# \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 How Long? \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Position \_\_\_\_\_ How Long? \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_  
 Spouse's SS# \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Position \_\_\_\_\_ How Long? \_\_\_\_\_  
 Spouse's Employer Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Name of Nearest Relative Not Living With You:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Whom may we thank for referring you?  
 \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT  
 OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ F \_\_\_\_\_ M \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer's Address \_\_\_\_\_  
 Employer's Phone \_\_\_\_\_

**PATIENTS COVERED BY INSURANCE**

Subscriber's Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_  
 Employer's Address \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Group No. \_\_\_\_\_  
 Have you used medical insurance previously?  Y  N

**SECONDARY INSURANCE INFORMATION**

Subscriber's Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Address \_\_\_\_\_

THIS ACCOUNT WILL BE PAID BY

CASH     CHECK     CREDIT CARD

DEBIT CARD (PATIENT LIABILITY)

I authorize all of the above information to be used as needed by Dental Sleep Medicine of Indiana to facilitate my medical treatment. I agree to assume the financial responsibility for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_  
 RESPONSIBLE PARTY

**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_ hereby assign all dental benefits to Harold A. Smith/Dental Sleep Medicine of Indiana. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

**HEALTH HISTORY**

General Health (Please Check):  Good  Fair  Poor

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Are you presently taking any medicine or drugs?  Y  N

If yes, list drug, dosage, and frequency \_\_\_\_\_

Allergic to Penicillin or any other drug?  Y  N

If yes, explain \_\_\_\_\_

Ever been hospitalized in the past 5 years?  Y  N

Have any excessive bleeding when cut?  Y  N

(Women) Are you pregnant?  Y  N

If yes, how long? \_\_\_\_\_

(Women) Are you taking oral contraceptives?  Y  N

If yes, did you know that antibiotics can decrease the effectiveness of birth control pills?  Y  N

Circle any of the following you have had or have presently:

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Condition         | <input type="checkbox"/> Liver Disease           |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Hepatitis A             |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Hepatitis B             |
| <input type="checkbox"/> Chest Pains (Angina)    | <input type="checkbox"/> Yellow Jaundice         |
| <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Cortisone Medicine      |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Arthritis or Rheumatism |
| <input type="checkbox"/> Anemia or Hemophilia    | <input type="checkbox"/> Alcoholism              |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Drug Addiction          |
| <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Cancer or Tumor         |
| <input type="checkbox"/> Swelling of the Ankles  | <input type="checkbox"/> Venereal Diseases       |
| <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Radiation Therapy       |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Chemotherapy            |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> HIV Positive/AIDS       |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Genital Herpes          |
| <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Cold Sores              |
| <input type="checkbox"/> Skin Rashes or Hives    | <input type="checkbox"/> Epilepsy or Seizures    |
| <input type="checkbox"/> Kidney Trouble          | <input type="checkbox"/> Psychiatric Treatment   |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Artificial Joint        |
| <input type="checkbox"/> Sickle Cell Disease     | <input type="checkbox"/> Artificial Implants     |

**DENTAL HISTORY**

Date of last visit to a dentist \_\_\_\_\_

Dentist's name \_\_\_\_\_ Phone \_\_\_\_\_

Did you have x-rays taken?  Y  N

Have you had all your teeth x-rayed in the past 3 years?  Y  N

Do you wear full or partial dentures?  Y  N  
If yes, how old are they? \_\_\_\_\_

Does any member of your family, including your parents, wear dentures?  Y  N

Have you had orthodontic treatment?  Y  N

Do you clench or grind your teeth during the day or night?  Y  N

Have you ever had pain in your jaw joint or your face (in or about your face)?  Y  N

Orthodontic appliances worn now or ever before?  Y  N

Does your jaw joint click or do you have difficulty opening your mouth widely?  Y  N

Do you have an unpleasant odor, or taste, in your mouth?  Y  N

Do your gums bleed when brushing?  Y  N

Have you had gum disease or pyorrhea?  Y  N

Is your mouth or teeth sensitive to:  
Pressure:  Y  N Cold:  Y  N Hot:  Y  N

Do you or any member of your family snore?  Y  N

Does food catch between your teeth every time you eat?  Y  N

Are you dissatisfied with the appearance of your teeth?  Y  N

How can we help? \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

Please add anything you feel is important for us to know:  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Patients Name \_\_\_\_\_ DOB \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**REFERRING PHYSICIAN**

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone \_\_\_\_\_

**REFERRING PHYSICIAN**

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone \_\_\_\_\_

**REFERRING PHYSICIAN**

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Have you had an overnight sleep study?  Y  N

If yes, when and where? \_\_\_\_\_

Have you gained weight recently?  Y  N If yes, how much? \_\_\_\_\_ lbsHave you used CPAP?  Y  N If yes, pressure level \_\_\_\_\_

If any, the reason for stopping: \_\_\_\_\_

How often did you use it? \_\_\_\_\_ Nightly \_\_\_\_\_ 3-6 Nights a Week \_\_\_\_\_ 3-6 Nights a Week \_\_\_\_\_ Rarely

Have you had an evaluation with an Ear, Nose and Throat (ENT) Physician?  Y  N

If yes, who and when? \_\_\_\_\_

Have you had any throat or nose surgery?  Y  N

If yes, what and when? \_\_\_\_\_

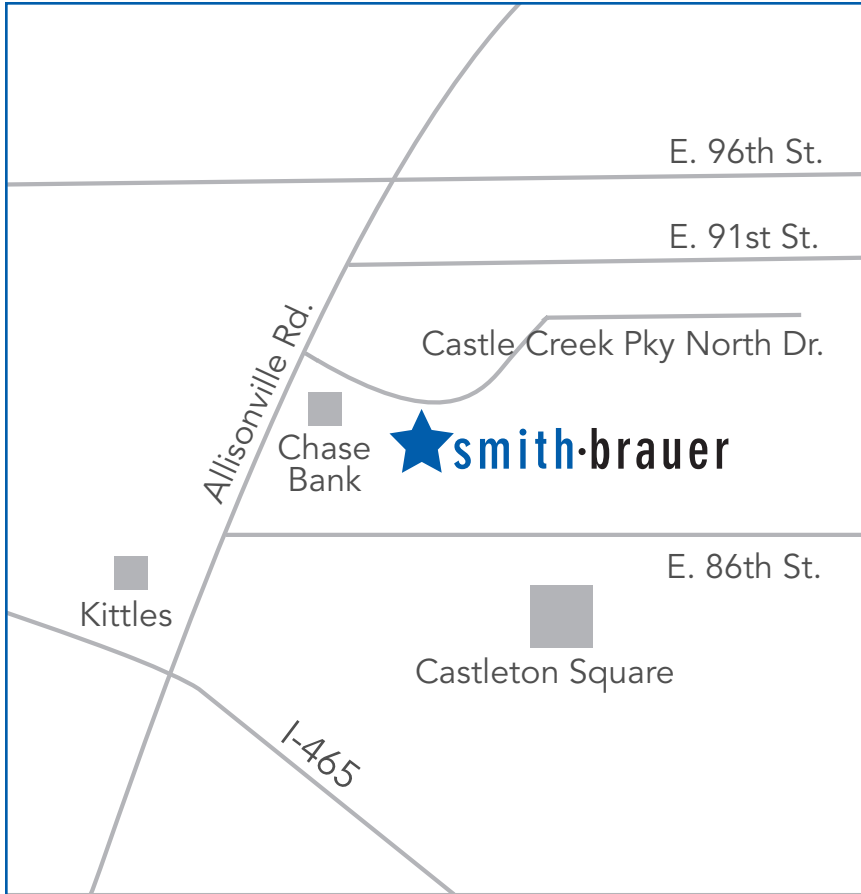
Does your jaw joint click or do you have difficulty opening your mouth widely?  Y  NDo you have daytime sleepiness?  Y  NDo you snore?  Y  NIs there a family history of snoring?  Y  N

How often do you awaken at night? \_\_\_\_\_

How often do you go to the bathroom at night? \_\_\_\_\_

I allow the release of all pertinent medical records to my insurance company and other medical providers:

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_



## DIRECTIONS TO DENTAL SLEEP MEDICINE OF INDIANA

Located at:  
Smith-Brauer Family & Cosmetic Dentistry  
8800 North on Allisonville Road  
5625 Castle Creek Parkway North Drive  
Indianapolis, IN 46250  
p: 317.585.0008  
f: 317.585.0006

snoringindiana.com  
smith-brauerdentistry.com

### Directions from South, East and West

Take I-465 to the Allisonville Road Exit. Go north on Allisonville Road. (You will pass 86th Street and at the next stop light you will see a Chase Bank on the eastside.) At the light go east (turn right). We are the first building east of Chase Bank on Castle Creek Parkway North Drive.

### Directions from the North

Take Allisonville Road south past 91st Street. At the next stoplight turn east (left) onto Castle Creek Parkway North Drive. We are the first building east of Chase Bank.

For assistance call:

**317.585.0008**

# Dental Sleep Medicine of Indiana

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

### SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office ManagerTelephone: 317-585-0008Fax: 317-585-0006

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Patient: \_\_\_\_\_ Relationship \_\_\_\_\_

Patient: \_\_\_\_\_ Relationship \_\_\_\_\_

Patient: \_\_\_\_\_ Relationship \_\_\_\_\_

Patient: \_\_\_\_\_ Relationship \_\_\_\_\_

Patient: \_\_\_\_\_ Relationship \_\_\_\_\_

### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**  
**Include completed Consent in the patient's chart.**

# Dental Sleep Medicine of Indiana

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgment\*\***

I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

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We attempt to obtain written acknowledgment or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refuses to sign
  - Communication barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining the acknowledgement
  - Other (Please Specify)
- 
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