diamond dental
SLEEP SOLUTIONS

Patient Intake Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Name: ______________________________ Preferred Name: ____________

Address: ______________________City/State/Zip:______________________

Date of Birth: ____/____/______ Email: ______________________________

Home phone:_____________ Cell: ______________ Work: ____________

Sleep Physician: ________________________ Phone: ____________

General Physician: ______________________ Phone: ____________

Dentist: ______________________________Phone: ____________

Other : ______________________________ Phone:____________

Concerns:

What Prompted You to Seek Diagnosis and Treatment? Please circle all that apply.

Sleep Apnea	Difficulty Falling Asleep	Morning Headaches
Insomnia	Wake up Gasping/Choking	Nasal Problems
Restless Legs	Neck or Facial Pain	Memory Problems
Snoring	Irritability or Mood Swings	Alternative to CPAP

Excessive Daytime Sleepiness (EDS)

I have been told I stop Breathing When I Sleep

Other:____

How long have you had the problem? ____________

Have you ever had a sleep study performed? Y N How long ago?__________

If yes, please name the provider who conducted your sleep study:

____

Patient Intake Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Have you ever tried an Oral Appliance? Y N

If yes, was it fabricated by a dentist? Y N

If yes, who fabricated it? ________________

If applicable, please describe your previous Oral Appliance experience:

____

____

Are you currently or have you ever used a CPAP? Y N

If Yes, how many nights per week do you currently wear it? ____________________

When you wear/wore your CPAP, how many hours per night do/did you wear it? ___

Treatment Will Be Successful When: ____

Dental History:

When was your last dental exam/cleaning? _________________________________

Any unfinished dental work? ____

Any Dental Concerns? ____

How Would You Describe Your Dental Health? Excellent Good Fair Poor

Have You Ever Had Teeth Extracted? Y N

Do You Wear Complete or partial removable dentures? Y N

If Yes, Please Describe: ____

Have You Ever Worn Braces (Orthodontics?) Y N

If Yes, Date Completed: ____________

Have You Ever Had Gum Problems? Y N

If Yes, Have You Ever Had Gum Surgery? Y N

diamond dental
SLEEP SOLUTIONS

Patient Intake Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Do You get Dry Mouth? Y N

Have You Ever Had an Injury to Your Head, Face, or Mouth? Y N

Have you been told You Clench or Grind Your Teeth? Y N

Does Your TMJ (Jaw Joint) Click or Pop? Y N

Do You Have Pain in the jaw joint? Y N

If You Answered Yes to Any Questions Above, Please Briefly Describe Your Answer:

____

____

____

____

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

Daily Occasionally Rarely/Never

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

Daily Occasionally Rarely/Never

How often do you consume caffeine within 2-3 hours of bedtime?

Daily Occasionally Rarely/Never

Do you smoke? Y N If yes, how many packs per day? _______

Do you use chewing tobacco? Y N If yes, how many times per day? _______

diamond dental
SLEEP SOLUTIONS

Health Information

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Have you ever had any of the following? Please check if applies:

Y N		Y N		Y N	
□□	AIDS or HIV	□□	Fainting or Dizziness	□□	Parathyroid disease
□□	Anemia	□□	Glaucoma	□□	Psychiatric Care
□□	Arthritis	□□	Hay Fever	□□	Radiation Treatment
□□	Artificial Heart valve	□□	Heart Attack/Failure	□□	Respiratory Problems
□□	Artificial Joints	□□	Heart Disease	□□	Rheumatic Fever
□□	Asthma	□□	Heart Murmur MVP	□□	Sinus Problems
□□	Blood Disease	□□	Heart PACE MAKER	□□	Stomach Problems
□□	Cancer	□□	Hepatitis A, B or C	□□	Stroke
□□	Chemotherapy	□□	High Blood Pressure	□□	Tuberculosis
□□	Diabetes	□□	Leukemia	□□	Tumors
□□	Drug Addiction	□□	Liver Disease	□□	Ulcers
□□	Epilepsy or seizures	□□	Kidney Disease	□□	OTHER:___________________________
□□	Excessive Bleeding				

Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex
□ Local Anaesthetic □ Other (if yes please explain)_________________________________

Have you ever had a head or neck injury? ( ) YES ( ) NO If yes please explain_________________________

Do you need to pre-medicate with antibiotics prior to dental work? ( ) YES ( ) NO If yes please explain
____

Do you or have you taken Fosamax? ( ) YES ( ) NO ____

Do you use, or have you used, tobacco? ( ) YES ( ) NO ____

Do you use controlled substances? ( ) YES ( ) NO ____

□ Please List ANY MEDICATIONS you are taking:____
____

WOMEN: Are you pregnant? ( ) YES ( ) NO

In Case of **EMERGENCY** give contact **NAME** and **CELLPHONE NUMBER:**
____

Are you now under the care of a physician or have you ever had a serious illness not listed above?
( ) YES ( ) NO If yes please explain____

Name of Physician: __________________________________ Phone:________________

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of Patient (or parent or guardian) ____________________________________

Relationship to Patient:_________________________ Date:_____________

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Patient Authorization, Assignment of Benefits & Financial Agreement

In return for the services provided by Diamond Dental Sleep Solutions, (the "Practice") I understand that all applicable copayments and deductibles are due at the time of service. I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment. I agree to be financially responsible and make full payment for all charges not covered by my insurance company, including in instances where my coverages lapses or if I fail to give the requisite insurance information to the office. I authorize my insurance benefits to be paid directly to the Practice for services rendered. I authorize representatives of the Practice to release pertinent information to my insurance company when requested or to facilitate payment of a claim. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me. In the event I receive payment from the insurance company for services rendered by the Practice and fail to remit such payment to the Practice immediately then I acknowledge and agree that I will be responsible for any fees, including legal fees associated with Dental Sleep Solutions' collection efforts from me. If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. If my account is delinquent, I may be charged interest at the legal rate. I agree to be primarily responsible for the payment of the Practice's bill.

I read and agree to all of the above.

Beneficiary Signature or Authorized Party: ___________________________________

Date:_____________

diamond dental
SLEEP SOLUTIONS

Epworth Sleepness Scale

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would never doze or sleep.
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Name: ______________________________________ Date: ________________

HEIGHT: Feet____Inches_____ WEIGHT: Pounds______ NECK SIZE:________

*CIRCLE ONE NUMBER IN EACH ROW AND THEN ADD UP YOUR "SCORE"

Situation	**Chance of Dozing or Sleeping**
Sitting and Reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place	0 1 2 3
Being a passenger in a motor vehicle for an hour or more	0 1 2 3
Lying down in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (no alcohol)	0 1 2 3
Stopped for a few minutes in traffic	0 1 2 3
Total Score	

0-5: It is unlikely that you are abnormally sleepy
6-9: You have an average amount of daytime sleepiness
10-15: You may be excessively sleepy depending on the situation
16-24: You are excessively sleepy

diamond dental
SLEEP SOLUTIONS

CPAP Intolerance Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Patient name: ______________________________ DOB: ______________

☐ **I have attempted to use the nasal CPAP device** to manage my sleep-related breathing disorder and find it intolerable to use on a regular basis for the following reason(s):

- ☐ Mask Leaks
- ☐ Mask and/or device uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise from the device disturbs me and/or my bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on upper lip causes tooth-related problems
- ☐ An unconscious need to remove mask at night
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Other: (explain history below)

____

____

____

☐ **I have never worn a CPAP** and I refuse to wear one because:

- ☐ Claustrophobia
- ☐ I travel and refuse to carry the CPAP machine and hose
- ☐ I cannot have my movement restricted while sleeping
- ☐ Latex allergy
- ☐ Other:____

Because of my unwillingness to use the CPAP device, I wish to have an alternative method of treatment. I would like to try an oral appliance in an attempt to control my snoring and obstructive sleep apnea.

Signature of Patient ______________________________ Date:__________

Authorization to Release Medical Information

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Date:____/____/______ Date of Birth: ____/____/______ SSN: ________________

Patient Name: ____

Address: ___________________________________City/State/Zip:___________________________________

I, the undersigned, do hereby grant permission for **Dr. Asher Diamond** to

☐ obtain from or ☐ release to:

____

(Name of person or institution the information will be coming from)

____

(Address of person or institution the information will be coming from)

The following information from the patient's clinical record:

☐ All necessary medical records

☐ Other: ____

I understand that this information will be used for the purpose of:

☐ Providing information to allow care to be provided to the patient

☐ Supporting the payment of an insurance claim

☐ Other: ____

This authorization will be valid for the period of twelve months unless otherwise specified below.

Signature of Patient or Patient's Authorized Representative ____

Relationship to Patient:____ Date:_____________

diamond dental
SLEEP SOLUTIONS

HIPAA Notice of Privacy Practices Acknowledgment Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

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. The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples include setting up appointments for you, examining your teeth, prescribing medications, referring you to another doctor, or getting copies of your health information from another professional, insurance, etc. By signing below, you acknowledge that you have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how your health information may be used and disclosed by Diamond Dental Sleep Solutions and how you may obtain access to and control this information.
The full Notice is available upon request.

☐ By checking this box, I expressly permit Diamond Dental Sleep Solutions to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

- Text messaging
- Home answering machine
- Cell phone voicemail
- Email
- Other (specify): ____

Signature of Patient ___________________________________ Date:____________

You may Refuse to sign this acknowledgement. If you refuse to sign, please indicate the reason:
Reason for Refusal to sign: ____

____

diamond dental SLEEP SOLUTIONS

Informed Consent for the Treatment of Sleep Disordered Breathing

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

You have been diagnosed by your physician as requiring treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels, which in turn, may result in the following: excessive daytime sleepiness, irregular heartbeats, high blood pressure, heart attack, or stroke. All individuals are advised to consult with a physician for accurate diagnosis of their condition before treatment can be started.

What is Oral Appliance Therapy?
Oral appliance therapy for snoring/obstructive sleep apnea attempts to assist breathing during sleep by mechanically keeping the tongue and jaw in a forward position, thereby opening the airway space. Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you, since everyone is different and there are many factors influencing 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 the symptoms related to your sleep disordered breathing. A post adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician. Oral appliance therapy does not cure snoring or obstructive sleep apnea. The device must be worn nightly for the duration of the disease, often for life.

Side Effects and Complications of Oral Appliance Therapy
Studies show that short-term side effects of oral appliance use may include excessive salivation, difficulty swallowing with appliance in place, sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term bite changes (how the upper and lower teeth come together). 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. Additionally, using an Oral Appliance, specifically a mandibular advancement device (MAD) to treat obstructive sleep apnea may worsen the symptoms of TMJ disease and associated pain could get worse and, in some instances, become permanent causing severe pain and disability. These complications may or may not be fully reversible once appliance therapy is discontinued.

If not, restorative or orthodontic treatment may be required, for which you will be responsible.
Follow up visits with Dr. Diamond are mandatory to ensure proper fit and to allow an examination of your mouth to assure 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 Disordered Breathing
Other accepted treatments for sleep-disordered breathing include behavioral modifications, positive airway pressure and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing 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 Dr. Diamond or the staff. Failure to treat sleep disordered breathing may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked Dr. Diamond or the staff any questions you may have about this form or treatment, please sign and date this form below. By your signature, you also acknowledge you have received a copy of this consent.

Signature of Patient ______________________________ Date:__________