Wake Dental Sleep
General Dentistry and Sleep Oral Appliance Therapy
Jennifer Q. Le. DMD, D-ABDSM, CPCC, ACC

American Academy of Dental Sleep Medicine
Dental Sleep Medicine Accredited Facility

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Diplomate of American Board of Dental Sleep Medicine

Dental Patient Registration

Patient Information

First Name:_____ Middle:_____ Last:_____

How did you hear about us?_____ Preferred Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Email address: _____

☐ By checking this box I agree to receive communications from the office regarding updates and promotions.

Birth Date:_____ Social Security #: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

How long has it been since your last dental exam?_____

Insurance Information – Provide office with insurance card

Patient's Relationship to Insurance Carrier: ☐Self ☐Spouse ☐Child ☐Other

Name of Insured if not patient: First:_____ Middle:_____ Last:_____

Insured Address:_____

City, State, Zip_____

Home Phone:_____ Work Phone:_____ Ext:_____Cellular:_____

Insured Birth Date:_____ Insured Soc Sec:_____

Employer:_____

Insurance Company:_____

Address: _____

City, State, Zip: _____

Phone:_____

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Medical History

NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes	O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	If yes, please explain: _____
Are you on a special diet?	O Yes	O No	If yes, please explain: _____
Do you use tobacco?	O Yes	O No	
Do you use controlled substances?	O Yes	O No	
Are you HIV Positive or have you been diagnosed with AIDS?	O Yes	O No	

Women: Are you
- O Pregnant/Trying to get pregnant?
- O Nursing?
- O Taking Oral Contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other If yes, please explain: _____

Do you have, or have you had, any of the following?

O AIDS/HIV Positive	O Chest Pains	O Frequent Headaches	O Irregular Heartbeat	O Scarlet Fever
O Alzheimer's Disease	O Cold Sores/Fever Blisters	O Genital Herpes	O Kidney Problems	O Shingles
O Anaphylaxis	O Congenital Heart Disorder	O Glaucoma	O Leukemia	O Sickle Cell Disease
O Anemia	O Convulsions	O Hay Fever	O Liver Disease	O Sinus Trouble/Sleep Apnea
O Angina	O Cortisone Medicine	O Heart Attack Failure	O Low Blood Pressure	O Spina Bifida
O Arthritis/Gout	O Diabetes	O Heart Murmur	O Lung Disease	O Stomach/Intestinal Disease
O Artificial Heart Valve	O Drug Addiction	O Heart Pace Maker	O Mitral Valve Prolapse	O Stroke
O Artificial Joint	O Easily Winded	O Heart Trouble/Disease	O Pain in Jaw Joints	O Swelling of Limbs
O Asthma	O Emphysema	O Hemophilia	O Parathyroid Disease	O Thyroid Disease
O Blood Disease	O Epilepsy or Seizures	O Hepatitis A	O Psychiatric Care	O Tonsilitis
O Blood Transfusion	O Excessive Bleeding	O Hepatitis B or C	O Radiation Treatments	O Tuberculosis
O Breathing Problem	O Excessive Thirst	O Herpes	O Recent Weight Loss	O Tumors or Growths
O Bruise Easily	O Fainting Spells/Dizziness	O High Blood Pressure	O Renal Dialysis	O Ulcers
O Cancer	O Frequent Cough	O Hives or Rash	O Rheumatic Fever	O Venereal Disease
O Chemotherapy	O Frequent Diarrhea	O Hypoglycemia	O Rheumatism	O Yellow Jaundice

O None of the conditions listed

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

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Please check the option that best applies:

	Never	Once per week	Several days per week	Daily
How often do you consume alcohol within 2-3 hours of bedtime?	☐	☐	☐	☐
How often do you take sedatives within 2-3 hours of bedtime?	☐	☐	☐	☐
How often do you consume caffeine within 2-3 hours of bedtime?	☐	☐	☐	☐

	Never	Occasionally	Daily	Number of cigarettes per day
Do you use tobacco? (Smoking, snuff, or chew)	☐	☐	☐	_____

Please check if any members of your family have had:

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Diagnosed or treated for a sleep disorder

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Medical History Continued:

Current Primary Care Physician Name: _____

Address: _____

_____

_____

Phone: _____

Fax:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A-Patient Giving Consent

Name _____

Address _____

Telephone _____ Email _____

Patient # _____ Social Security # _____

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 at 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: Jennifer Q. Le, DMD
Telephone: 919-488-0111
Fax: 919-488-0104
Address: 2810-115 Wakefield Pines Drive, Raleigh, NC 27614

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you 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.

SIGNATURE

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.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

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

_____

_____

_____

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Office Policies

Effective 04/26/2006

- **A complete exam includes x-rays**. The x-rays consist of 4 Bitewing x-rays, a panoramic x-ray and periapical (root x-ray) x-rays of certain teeth. Anything not covered by insurance will be your responsibility. If you have recent x-rays (bite wings less than one year and panoramic less than three years) at another dentist we ask you to have them emailed to us.

- If you have not had regular dental care it may be necessary to perform a general debridement in order to diagnose the health of your gums. A scaling and root planing may be recommended in some case. If either of these procedures is necessary the hygienist will discuss this with you prior to treatment.

- An adult, 18 years old or older, must accompany all patients under the age of 18. A signed waiver may be accepted from a parent/guardian for certain procedures.

- Your estimated portion is due at the time service is rendered. There are times when an insurance company will pay more than expected. In these circumstances any money owed to the patient under the amount of $100.00 will be left as a credit on the account. Refunds will be mailed within 4 to 6 weeks.

- Patients that cancel without a **24-hour notice** or no show will be charged a cancellation fee of **$25.00 per half hour**.

- We are happy to file insurance for you but please be aware that any portion not paid by your insurance will be your responsibility. We contact your insurance company prior to your new patient appointment to verify benefits and to obtain a general benefits breakdown. We will give you an estimate for any proposed treatment however it is your responsibility to be familiar with your dental plan. We are not responsible for any discrepancies between our estimate and the actual payment from your insurance company.

PLEASE NOTICE:
It is our office philosophy to try to provide our patients with the most up to date techniques and materials available in dentistry. When doing fillings, we use composite resin (tooth colored fillings) because they allow a more conservative and esthetic result. Amalgam (silver) fillings are reserved for circumstances when proper isolation is difficult. We understand that you may prefer to have amalgam fillings. If so, we can refer you to a dentist nearby.

Some insurance companies do not cover composite resins, only amalgam (silver). Once Dr. Le has gone over your treatment plan with you we will give you a print out of the total **estimated** charges. The **estimate** will have a break down of your portion and the insurance portion. We will not know the exact amount of coverage until the claim has been submitted, and we receive payment.

We appreciate the opportunity to provide you with care, in understanding that these office policies help our office run smoothly. If you would like a copy of our office policies please let us know.

I _____have read the information and fully understand its content.

_____ _____
Signature Date

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Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Wakefield Family Medicine & Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other
❑ Give information to employer ❑ Give information to school	❑ Appointment absentee information
❑ Spouse	❑ Family billing information ❑ Financial ❑ Medical as follows:
❑ Parent (provide name)	❑ Family Billing Information ❑ Financial ❑ Medical as follows:
❑ Other (provide name)	❑ Financial ❑ Medical as follows
❑ Support Group (provide name)	❑ Demographic Information

Rights of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Wakefield Family Medicine & Dentistry.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)_____

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Getting To Know You!

Patient Name _____ Date _____ Birth Date _____/_____/____

Occupation: _____

List all family members currently seen at our office: _____

_____

Who selected our office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

How did you hear about our office? _____

❑ Referred by friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon
❑ TV/Radio ❑ Newspaper ❑ Direct Mailing ❑ Sign by Building ❑ Other _____

Dental History

Do you floss? Y / N
If yes, how often? _____

How often do you brush? _____

(Please circle each that applies to you)

Y N I clench or grind my teeth during the day or while sleeping
Y N My gums bleed while brushing or flossing.
Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.
Y N I have a history of oral cancer.
Y N I've been told previously I have gum disease.
Y N My gums feel tender or swollen.

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Answer Y or N

Functional Outcomes of Sleep Questionnaire

Q1. Do you generally have difficulty concentrating on the things you do because you are sleepy or tired?

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

Q3. Do you have difficulty finishing a meal because you become sleepy or tired?

Q4. Do you have difficulty working on a hobby (for example: sewing, collecting, gardening) because you are sleepy or tired?

Q5. Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?

Q6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?

Q7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?

Q8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?

Q9. Do you have difficulty taking care of financial affairs and doing paperwork (for example: writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?

Q10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?

Q11. Do you have difficulty maintaining a telephone conversation because you become sleepy or tired?

Q12. Do you have difficulty visiting with your family or friends in your home because you become sleepy or tired?

Q13. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?

Q14. Do you have difficulty doing things for your family or friends because you are too sleepy or tired?

Q15. **For Question 15 answer using only 1, 2, 3 or 4.** Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

Q16. Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?

Q17. Do you have difficulty watching a movie or videotape because you become sleepy or tired?

Q18. Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?

Q19. Do you have difficulty enjoying a concert because you become sleepy or tired?

Q20. Do you have difficulty watching television because you are sleepy or tired?

Q21. Do you have difficulty participating in religious services, meetings or a group or club because you are sleepy or tired?

Q22. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

Q23. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

Q24. Do you have difficulty being as active as you want to be in the afternoon because you are sleepy or tired?

Q25. Do you have difficulty keeping pace with others your own age because you are sleepy or tired?

Q26. **For Question 26 only, answer using the scale below.**
How would you rate your general level of activity?
1 = Very Low; 2 = Low; 3 = Medium; 4 = High

Q27. Has your intimate or sexual relationship been affected because you are sleepy or tired?

Q28. Has your desire for intimacy or sex been affected because you are sleepy or tired?

Q29. Has your ability to become sexually aroused been affected because you are sleepy or tired?

Q30. Has your ability to have an orgasm been affected because you are sleepy or tired?

The FOSQ questions are complete.
Thank you for completing this questionnaire.

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The Epworth Sleepiness Scale

Name: _____

Today's Date: _____

Your Age (years): _____

Your Sex: ____ Male ____ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation:	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater or 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	_____

UNDERSTANDING YOUR SCORE
0–10: Normal range in healthy adults
11–14: Mild sleepiness
15–17: Moderate sleepiness
18 or higher: Severe sleepiness
If you scored 11 or higher, consider seeing a sleep medicine specialist to diagnose and treat the cause of your sleepiness.

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Questionnaire of Sleep Apnea and/or Snoring

Name: _____ Date: _____

1. How long have you been aware of your snoring? _____
2. Has it caused problems for relatives or friends? _____
3. Have you been told you move around a lot while asleep? _____
4. Have you been told your breathing stops while asleep? _____
5. About how many time per night do you wake up? _____
6. Do you have any difficulty falling asleep at night? _____
7. How many hours of sleep per night do you get? _____
8. Do you most often wake up feeling refreshed? _____
9. Do you often wake up with a headache? _____
10. Will a small amount of alcohol give you a hangover? _____
11. Do you feel sleep during the day? Frequently occasionally seldom never
12. What other doctors have you seen about your snoring or sleep apnea?
13. Have you had a sleep lab study? Yes No
14. Do you have difficulty breathing through your nose? Yes No
15. Have you gained weight recently? _____ About how much? _____
16. Present body weight: _____ Height: _____ft. _____inches
17. What professional advice or treatment have you received about your snoring or sleep apnea?

_____

_____

Signed _____ Date _____

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AFFIDAVIT FOR INTOLERENCE TO CPAP

Name: _____

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

__Mask leaks
__Mask uncomfortable / Device uncomfortable
__Unable to sleep comfortably
__Noise disturbs my sleep and/or bed partner's sleep
__Restricts movement during sleep
__Does not seem to be effective
__Straps/head gear cause discomfort
__Pressure on the upper lip cause tooth related problems
__Latex allergy
__Claustrophobic
__An unconscious need to remove in the night
__Other_____

Because of my intolerance to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is an oral appliance for mandibular repositioning as prescribed to me by Dr. Jennifer Q. Le, DMD.

Signed: _____

Date: _____

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OUR POLICY REGARDING ACCOUNT BALANCES

We value all of our patients and, for that reason, we try to keep all accounts in good standing. Therefore;

1. The portion of the service fee not covered by insurance is due at time of service. Payment may be made in cash or by any major credit card.

2. While we can estimate probable insurance coverage, please understand that this is only an estimate based on the best information available to us and is not guaranteed to be 100% accurate.

3. If your insurance company has not remitted payment after 45 days, the balance will automatically become your responsibility.

4. Any balance which remains unpaid after 45 days, whether partially paid by insurance or not, may be charged interest at a rate of 1.5% per month.

5. If you find that you are unable to pay the entire balance at once, please speak with any member of our staff about a Dental Payment Plan (Care Credit), which is available to qualified applicants.

Hopefully, the above information has been helpful. Questions regarding our office policies are strongly encouraged.

Patient's Signature Date

Patient's Printed Name Date

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Dental History

Current Dentist:

_____

Practice Name:

_____

Practice Address:

_____

Practice Phone Number:

_____

Date of Last Dental Exam:

_____

Date of Last Radiographs:

_____

I, _____ confirm that I do NOT have any outstanding dental treatment that has been proposed.

I, _____ acknowledge that any x-rays (including panoramic) that are necessary for my treatment are my responsibility if not covered by my insurance.

Print Name: _____ Date:_____

Signature: _____ Date: _____