NEW PATIENT FORM:

PATIENT INFORMATION:

FIRST NAME: _____ LAST NAME: _____ MI: ___
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Best time to call: Morn/Noon/Night Call: Home/Cell/Work
Email: _____DOB: ___/___/___ SS# _____
Height: _____ Weight: _____
Address: _____ City _____State ____Zip _____ Marital Status: S/M/D/W
Emergency Contact: _____ Relationship: _____
Phone: _____ Referred by:_____

EMPLOYER INFORMATION: Employer: _____
Phone: _____ Fax: _____
Address: _____ City _____ State ____ Zip _____

INSURANCE INFORMATION:
Insurance Company Name:
Group Policy/TWCC #:_____ Group Name: _____ Ins ID#_____
Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company
FIRST NAME: _____ LAST NAME: _____ MI: ___
Home Phone: _____ Cell Phone: _____Work Phone: _____ DOB:___/___/___
Email: _____ Employed by: _____
Address: _____ City _____State ____Zip _____

SECONDARY INSURANCE INFORMATION: Insurance Company Name:
Group Policy/TWCC #:_____ Group Name: _____Ins ID#:_____
Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company
FIRST NAME: _____ LAST NAME: _____ MI: ___
Home Phone: _____ Cell Phone: _____Work Phone: _____ DOB:___/___/___
Email: _____ Employed by:
Address: _____ City _____State ____Zip _____

MEDICAL CONTACTS: Norcal Snore and Sleep Solutions coordinates treatment with your other medical providers to ensure
maximum benefit to you. Where applicable, please list your other medical providers:

PRIMARY CARE DOCTOR: _____ PHONE: _____
ENT: _____ PHONE: _____
DENTIST: _____ PHONE: _____
OTHER DOCTOR: _____ PHONE: _____
OTHER DOCTOR: _____ PHONE: _____

I CERTIFY THIS INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
INITIAL: _____ DATE:___/_____/____
SLEEP PHYSICIAN: _____ Phone:_____
Location of Sleep Study:_____ Phone:_____
Date of Baseline Sleep Study:_____Date of Titration Sleep Study:_____
Treatment Attempted: Weight Loss PAP Oral Appliance (Custom)
PAP Trial Started: ___/____/___ Last Worn: ___/____/___ DME Provider:_____
Patient Chief Complaint and Patient Expectations:
Briefly describe your problem with your sleep as you see it:
What is the nature of assistance you expect or desire?
Sleep History:
Have you ever had your sleep evaluated before? Y/N Sleep Study Date: __/___/___ PSG/HST
What were you told your final assessment (diagnosis) was? _____
What treatment options were you offered?
PAP Oral Appliance Surgical Weight Loss
What promoted todays evaluation?_____
Have you ever had oral surgeries to treat your sleep symptoms? Y/N Type:_____
Do you work swing shift or night shifts? SWING/NIGHT

Have you had or currently have any of these conditions? Please circle the appropriate answer below:

High Blood Pressure	Yes	No	PAP	Yes	No
Heart Disease	Yes	No	Weight Loss	Yes	No
Heart Attack/Stroke	Yes	No	Nose Cones or Strips	Yes	No
Mood Disorder	Yes	No	Side Sleeping	Yes	No
Impaired Thinking	Yes	No	Surgical Treatments	Yes	No
Insomnia	Yes	No	Mask Type: NP Nose Full Mask		

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following circumstances, in contrast to feeling just tired? This refers to your usual way of life in recent times, not in the far past.

Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in a public place (i. e. a theatre)	0 1 2 3
A passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when possible	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3

Total_____

Rank Your Overall Quality of Sleep: POOR AVERAGE GOOD

Printed Name_____ Signature_____Date _____

NorCal Snore and Sleep Solutions Inc.
Better Sleep, Better Life

Informed Consent for Evaluation of TMJ Health and Oral Structure Stability

SLEEP APPLIANCE AND DIAGNOSTIC RECORDS

Please initial the space before each statement in acknowledgement of reading and understanding. Thank you.

_____ 1. Please be advised that the medical and dental treatment of the human body is not an exact science. In light of this, ideal or perfect results may not be achieved and cannot be guaranteed. The most advanced technology available for the assessment, treatment and management of your condition will be used to the utmost of our ability.

_____ 2. You need to have a medical clearance from your physician(s) to eliminate problems that are beyond our area of expertise such as tumors of the head and neck. Furthermore, you should get a written referral from your physician on or before the comprehensive diagnostic appointment; this often aids in receiving reimbursements from your medical insurance.

_____ 3. Some insurance companies do not pay for Sleep Disordered Breathing treatment. We will generate your insurance form at no charge, and your insurance company is responsible for sending payments directly to you. Any discrepancies are strictly between you and your insurance company. You are responsible or forwarding that insurance reimbursement if your account has not already been paid in full. You are also responsible for any amount with-held by the insurance carrier and applied to your deductible or out-of-pocket expenses.

_____ 4. We will not render any treatment until you have signed and dated the Informed Consent. Please be advised, however, that you are not responsible for any payments for services not rendered.

_____ 5. The patient or parent, if applicable, hereby grants the treating dentist permission to use the diagnostic and treatment photographs, radiographs, study models, and records for the purpose of display, scientific articles, books, seminars, and other professional and public presentations. Names will be removed.

_____ 6. I agree to have my spouse or significant other attend the consultation appointment where the information of the screening evaluation will be reviewed so that they are aware of the information found.

_____ 7. I acknowledge that the information obtained in the records appointment is necessary for selection of the appliance most appropriate for the treatment of my compromised airway during sleep.

_____

Patient/Parent Signature **Printed** **Date**

_____

Witness/Employee Signature **Printed** **Date**

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Informed Consent

For the Treatment of Sleep Disordered Breathing with Oral Appliances

Snoring, Upper Airway Resistance Syndrome and Obstructive Sleep Apnea are breathing disorders that occur during sleep due to narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may often be no more problematic than the noise itself. However, consistent, loud, heavy snoring has been linked to medical disorders such as high blood pressure. Upper Airway Resistance Syndrome is a condition where the oxygen levels are maintained, but the amount of effort required to maintain those levels places an increased level of stress on all the other organ systems. Obstruction Sleep Apnea is a serious condition where the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, this can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure and occasionally heart attack and stroke.

Because any sleep disordered breathing may potentially represent a health risk, all individuals will be tested for reduced oxygen levels utilizing a pulse-oximeter, an ambulatory sleep recorder and/or an in-house sleep center based polysomnogram.

Oral appliances may be helpful in the treatment of Snoring, Upper Airway Resistance Syndrome (UARS), and Obstructive Sleep Apnea (OSA). Oral appliances are designed to assist breathing by keeping the jaw and tongue forward, thereby opening the airway space in the throat. While documented evidence exists that oral appliances have substantially reduced snoring and sleep apnea for many people*, there are no guarantees this therapy will be successful for any individual*. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrowing airway space in the throat and excess weight. Since each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or apnea or everyone, therefore there is no guarantee of success of treatment of your condition with an oral appliance.

POSSIBLE COMPLICATIONS: Some people may not be able to tolerate the appliances in their mouth. Also, many individuals will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and a slight change in their “bite”. However, these usually diminish within an hour after appliance removal in the morning. On a rare occasion, a permanent “bite” change may occur as well as movement of the teeth. Acceptance of these possibilities is important in the consideration of wearing an oral appliance for your compromised airway. Oral appliances can wear and break. The possibility that these may be swallowed exists.

LENGTH OF TREATMENT: The oral appliance is strictly a mechanical device, known as a piece of Durable Medical Equipment, to maintain an open airway during sleep. It *does not cure* snoring or sleep apnea. Therefore, the device must be worn nightly for a lifetime to be effective. Overtime, simple snoring may develop into sleep apnea. Sleep Apnea may also become worse. Therefore, the appliance may not maintain its effectiveness over time. The oral appliance needs to be checked annually to ensure proper fit and the mouth also needs to be examined to assure a healthy condition. If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation.

Individuals who have been diagnosed as having Sleep Apnea may notice that after sleeping with an oral appliance they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high is to be re-tested with a pulse oximeter. This will be repeated until an acceptable improvement is noted. A Home Sleep Test will be re-run by the secondary or primary care physician or a follow-up in-house polysomnogram for verification of effective treatment of your breathing disorder.

UNUSUAL OCCURRENCES: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root restorations, non-vital teeth, muscle spasms, and ear problems are all possible occurrences. The sensation of a change in your bite is also a probability but does not typically affect your ability to eat.

Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

OFFICE PHONE: (916) 542-7996

APPLIANCE REPLACEMENTS: Your original appliance is included as part of your initial Sleep Apnea Appliance Fee. There will be a charge or any replacements due to accidental loss or negligent misuse. Our appliance replacement fee is $800.00 for a provisional appliance, $1985.00 for a permanent lab fabricated custom fit appliance. Replacement of sleep apnea appliances due to loss or negligent misuse is a non-covered insurance benefit. Please understand you are financially responsible for yourself and/or dependents if your appliance is lost or broken due to accidental loss, negligence or misuse. Pet consumption or partial consumption is included in this list.

APPLIANCE REPAIR: We anticipate reasonable visits to adjust or repair appliances such as: acrylic, bands and pins. There will be a charge for excessive office visits and materials used based on each individual case.

FOLLOW UP CARE: Fabrication and delivery of the appliance does not terminate the treatment process. Titration must be completed and verified. Follow up with your primary medical care provider is required as well as monitoring of current medications and resolution of symptoms. Annual visits are also required thereafter with this office as with your primary dental provider for oral health stability. Fees associated with those appointments are not included in the initial treatment process, but are critical in keeping.

I certify that I have read, or have been read to me, the contents of this form. I realize and accept any risks and limitations involved, and do consent to treatment.

_____

Patient/Parent Signature **Printed** **Date**

_____

Witness/Employee Signature **Printed** **Date**

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MEDICAL HISTORY:

It is important that we know your medical history. Many things have a direct bearing on your sleep health. Information you give us is strictly confidential and will not be released to anyone without your permission.DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? PLEASE √ (check) YOUR ANSWER

- Abrupt awakenings
- Hepatitis Type:_____
- Hip or Joint replacement
- Latex Allergy
- Mitral Valve Prolapse
- Nervous Problems/Disorders
- Radiation Treatment
- Restless leg syndrome
- Sinus Problems
- Snoring
- Stroke
- Tuberculosis
- Alcoholism
- Allergies to medications
- Anemia
- Asthma
- Blood Disease
- Cancer
- Circulatory Problems
- Convulsions/Seizures
- Diabetes Type __
- Excessive Bleeding
- GERD
- Heart Disease
- Heart Valve, Murmur
- High Blood Pressure
- Kidney Disease
- Lupus
- Neck & Back Problems
- Pacemaker
- Respiratory Problems
- Seizures/Fainting spells
- Sleep Apnea
- Stomach Ulcers
- Thyroid Disease
- Use a CPAP
- Allergies
- Allergies to metals
- Arthritis
- Atrial Fibrillation
- Bone Disease
- Chest Pain
- Congestive heart failure
- Daytime sleepiness
- Dry mouth/sore throat
- Glaucoma
- Hearing Impaired

PLEASE LIST ALL MEDICATIONS, INCLUDING VITAMINS AND OVER THE COUNTER MEDICATIONS:
i.e., aspirin, vitamins, herbs, etc. _____

_____

Do you drink Coffee or Tea? _____ How many cups in a day? _____
Do you use Tobacco? YES/NO Smoking ___ Dipping ___

_____

Patient/Authorized Signature Printed Date

NS3 NorCal Snore and Sleep Solutions Inc.
Better Sleep, Better Life

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form I acknowledge that I have received or reviewed the Notice of Privacy. I agree to allow NORCAL SLEEP MANAGEMENT to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize NORCAL SNORE AND SLEEP SOLUTIONS to leave messages for me when I am unavailable. I also understand that I have the right not to sign this agreement.

METHOD	NUMBER	DETAILED MESSAGES (YES OR NO)	
___ Home Phone	(___) _____	Yes	No
___ Cell Phone	(___) _____	Yes	No
___ Work Phone	(___) _____	Yes	No
___ Alternate phone	(___) _____	Yes	No
___ Text Messages	(___) _____	Yes	No
___ Email	_____	Yes	No
___ Home mail	_____	Yes	No

I authorize NORCAL SNORE AND SLEEP SOLUTIONS and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.
I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.
NAME/RELATIONSHIP TO PATIENT/CONTACT INFO _____

_____

EMERGENCY CONTACT: NAME:_____Phone:_____

In general, the HIPPA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI) the individual is also provided the right to request confidential communication.
By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that NORCAL SNORE AND SLEEP SOLUTIONS may impose.

_____

Patient/Authorized Signature Printed Date

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Better Sleep, Better Life

General Release of Liability & Assumption of Risk for Obstructive Sleep Apnea and Sleep Disordered Breathing

I, _____, understand that due to the nature of sleep medicine that failure to comply with the treatment can result in severe physical and social issues including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; hypertension; excessive sleepiness; and increased mortality. As this office cannot ensure success of any type of therapy and cannot guarantee that any patient will comply with the treatment for sleep apnea, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I might sustain as a result of my treatment for sleep apnea or any failure on my part to comply with treatment.

Therefore, I release this office and its affiliates from any and all liability associated with my treatment and I personally assume all risks associated with my care, including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; increased work place accidents; hypertension; excessive sleepiness; TMJ disease; periodontal disease and increased mortality.

I hereby agree to indemnify and hold this office and its affiliates harmless for any issues or damages that might result from my sleep apnea treatment.

Patient Signature _____ Date_____

Patient Print _____

Witness/Employee Signature _____ Date _____

Witness/Employee Print _____

NON DENTIST-OF-RECORD RELEASE FORM

Norcal Sleep Management
2180 E. Bidwell St., Ste. 100 Folsom CA 95630
P: 916-542-7996
F: 916-983-6100
Email: contactus@norcalsleepsolutions.com

I _____ am seeking treatment with a sleep orthotic appliance only. I understand that I am not a dental patient-of-record with Dr. Sirisha Krishnamurthy. The importance of regular dental care has been explained to me and I understand that Dr. Sirisha Krishnamurthy will not be responsible for providing my preventative or emergency dental needs. At this time, I choose to have my routine and necessary dental care completed in another office.

Patient signature _____

Patient Print _____ Date _____

Witness/Employee Signature _____

Witness/Employee Print _____ Date _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELIABLE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I request and authorize to release all healthcare information pertaining to the patient for the past year focused on all notes pertinent about patients past and present history regarding any and all sleep reports, pulmonary records, etc to:

Norcal Snore and Sleep Solutions
2180 E. Bidwell Ste., Ste 100
Folsom, CA 95630
P: 916-542-7996
F: 916-983-6100
Email: contacus@norcalsleepsoltions.com

I hereby authorize and instruct to transfer copies of records to the address listed above.

Patient Signature _____ Date _____

This authorization expires ninety (90) days after it is signed

AFFIDAVIT FOR INTOLERANCE TO CPAP

I, _____, make this statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts, and things set forth are true and correct to the best of my knowledge.

Dr. _____ has prescribed the nasal CPAP to manage my sleep related breathing disorder (apnea) and it has been advised that it is the GOLD STANDARD OF CHOICE for treatment of Obstructive Sleep Apnea.

I **HAVE ATTEMPTED** to use a CPAP/BIPAP/APAP and find it intolerable to use on a regular basis for the following reason(s).

(PLEASE CHECK ALL THAT APPLY)

- ☐ Mask leaks
- ☐ Mask and/or device is uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise from the device disturbs me and/or my partners sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on upper lip causes tooth-related problems
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Other: _____

OR

I **HAVE NOT ATTEMPTED** to use a CPAP/BIPAP/APAP device and would prefer to use an oral appliance, for the following reason(s).

(PLEASE CHECK ALL THAT APPLY)

- ☐ I am worried the mask, straps, headgear will cause discomfort
- ☐ I am worried the noise from the device will disturb me and/or my partners sleep
- ☐ I am worried the device will restrict movement during sleep
- ☐ I have a latex allergy
- ☐ I suffer from claustrophobia
- ☐ I travel frequently and am worried that a CPAP/BIPAP/APAP device will be cumbersome to transport
- ☐ Other: _____

By signing this consent form, I acknowledge that I have been made aware of reasonable alternatives to MAD therapy for Obstructive Sleep Apnea including, but not limited to: tracheotomy; CPAP; oral or pharyngeal surgery; positional sleep therapy; weight loss and exercise. Additionally, I am aware that more than one treatment may be necessary for the best results.

PATIENT SIGN: _____ DATE: _____

PATIENT PRINT: _____

PHYSICIAN SIGN: _____ DATE: _____

PHYSICIAN PRINT: _____

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization. I hereby assign and convey directly to the below-named health care provider ("Provider"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of its managed care network participation status.

I understand that I am financially responsible to the Provider for any charges regardless of health care benefits. It is my responsibility to notify the Provider of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I hereby authorize the Provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the Provider or its attorneys in order to claim such medical benefits.

In addition, I also assign and/or convey to the Provider any legal or administrative claim or choose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the Provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the Provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. PROVIDER: NORCAL SLEEP MANAGEMENT INC, Dr. Sirisha Krishnamurthy 2180 E. Bidwell St. Suite 100, Folsom, CA 95630

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient/Parent Signature	Printed	Date
Witness/Employee Signature	Printed	Date

NS3 Better Sleep, Better Life | NorCal Snore and Sleep Solutions Inc.

Outcome of Therapy

Our goals for your therapy

Our primary goal is to reduce your AHI to at least half that it was prior to therapy with the oral appliance. Our secondary goal is to reduce your AHI to less than 5 events per hour. By doing this we anticipate that you will be more alert and more energetic during the day. It is further possible that you may see a reduction in the amount medications that you regularly use to treat conditions like hypertension or diabetes.

Your Goals for Oral Appliance Therapy

_____

_____

_____

_____

Pt/ Guardian Signature _____

Pt/ Guardian Print _____ Date _____

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I, _____ herby authorize, _____
Relationship to patient is _____to release and/or make decisions on my behalf. They have been given my permission to discuss the following:

- Scheduling/cancelling appointments
- Treatment plans/options
- Financial responsibilities
- Progress notes
- Xrays
- Reports in chart
- Correspondence with Dr's and staff
- Signing any forms or documents

Reason may be: legal guardian, power of attorney, parent, disability, other.

IF THERE ARE ANY LEGAL DOCUMENTS PERTAINING TO THIS I WILL MAKE SURE TO BRING A COPY PRIOR TO NEXT VISIT.

Patient sign:_____Date _____

Guardian Sign:_____Date _____

Employee/Dr Sign: _____Date _____