



COMPREHENSIVE HEALTH QUESTIONNAIRE



Dedicated Sleep

Florida Dental Sleep Disorders
Kenneth A. Mogell D.M.D. A.B.D.S.M.

The purpose of this questionnaire is to determine the nature of your health problem. It is very important to be as accurate as possible in answering the questions. Your partner may be able to assist you.

***Please remember to write your name at the top of each page.**

General Information *(This information will become part of your medical record and will remain confidential.)*

Patient Name: _____ Date: _____

(First) (Middle) (Last)

Address: _____

(Street) (City) (State) (Zip)

Home Phone _____ Work Phone: _____

Cell Phone: _____ May we call you at work? _____

Email: _____ Best way to reach you? **Select One**

Date of Birth: _____ Age: _____ Sex: Male Female

Height: _____ Weight: _____ lbs. Marital Status: Single Widowed
 Divorced Married/Partner

SSN: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referring Physician: _____ Primary Care Physician: _____

Medical History

List current medical conditions for which you are being treated.

Diagnosis _____ Year _____ Treating Physician _____

List all hospitalizations and surgeries you have had. *(Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Diagnosis _____ Year _____ Treating Physician _____

List medications you are currently taking. *(Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

Medication _____ Reason _____ Dosage _____ How often _____

Please list any allergies we should be aware of:



Patient Name: _____ DOB: _____ DOS: _____

Health Questions (Please answer the best you can)

Are you unable to sleep in a flat position due to shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a family history of snoring or other sleep disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe:		
Have you ever sustained a brain concussion, head injury or serious blow to the head?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have spells or seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced a weight gain in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how much weight?		
Has your shirt collar size increase recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, by how much?		
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many packs per day?	How long have you smoked?	
Have you quit smoking?		
How many packs per day prior to quitting?	How long did you smoked?	Year quit?
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please estimate the number of drinks per day. (beer, wine, or liquor)		
Do you drink caffeinated drinks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please estimate the number of drinks per day. (sodas, coffee, or tea)		
(Female) Have you gone through menopause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(Males) Have you experience any prostate issues? (i.e. Frequent urination)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sleep Health Concerns & Habits

Describe your sleep problem(s) in your own words.

Describe how and when this problem began.

Describe any treatments you have received for your problem.

Has this been a continuous problem? Constant

Comes and goes Occasional Frequent

How long has your sleep problem bothered you?

Greater than 2yrs. 1-2 yrs. Several Months Last 3 Months Within the month

What time do you usually go to bed? Week Days: _____ Weekends: _____

What time do you usually wake up? Week Days: _____ Weekends: _____

How many hours of sleep do you usually get per night?

How long does it take you to fall asleep?

If you awake in the middle of the night, how long are you typically awake for?

Which shift do you work? (Check all that apply) Day Evening Night

Sleep Questions	Never	Rarely	Often	Frequent	Always
How often do you rotate shifts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your job require overnight travel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol after 6pm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink caffeinated beverages after 6pm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from a loss of libido?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Males) Have you experienced difficulties with sexual functions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Patient Name: _____ DOB: _____ DOS: _____

Dedicated Sleep

Sleep Questions	Never	Rarely	Often	Frequent	Always
(Females) Does your sleep problem vary according to the stage of your menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Females) Have you gone through menopause or had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to fall asleep and awaken on a daily, weekly basis according to your desired schedule?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you nap during the day or evening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel refreshed after a typical night's sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel sleepy during the day even when you have slept all night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel refreshed after a short nap?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get sleepy while driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an accident or near-accident when driving, due to excessive sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to fight off the excessive sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have memory or concentration problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience vivid dream-like scenes upon awakening or falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you are angry or laugh, do you ever feel weak, as though you might fall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever unable to move or speak upon falling asleep or awakening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble falling asleep when you go to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you try to fall asleep does your mind race with thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you try to fall asleep do you feel pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you a light sleeper, easily awakened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your sleep disrupted because of your bed partner or others in your household?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your snoring stop for brief periods during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your breathing sometimes stop during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your bed partner disturbed by your snoring?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up choking or gasping for breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heartburn at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nasal / sinus congestion at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have morning headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you a restless sleeper, tossing and turning at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience any type of leg or back pain during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Patient Name: _____

DOB: _____

DOS: _____

Dedicated Sleep

Do you wake up with sore or aching muscles or joints (including leg or back pain)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you walk or talk in your sleep as a child or adolescent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you now walk or talk in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frightening dreams or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your dreams or nightmares awaken you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wet your bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Sleep Concerns:					

Temporomandibular Joint Disorder (TMJ/TMD) & Pain Concerns

Symptom Questions	Right Side	Left Side		Right Side	Left Side
Do your symptoms affect one or both jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>	Pain in forehead	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the jaw joint?	<input type="checkbox"/>	<input type="checkbox"/>	Pain in facial area	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the ear?	<input type="checkbox"/>	<input type="checkbox"/>	Grating sound in joint	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain around the eyes?	<input type="checkbox"/>	<input type="checkbox"/>	Subjective hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Pain in lower jaw	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (vertigo)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in upper jaw	<input type="checkbox"/>	<input type="checkbox"/>	Upset stomach- nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in neck	<input type="checkbox"/>	<input type="checkbox"/>	Do you have arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had cervical traction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ringing sound in ears (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	Fullness, pressure blockage in ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Pain in tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total inability to open mouth	<input type="checkbox"/>	<input type="checkbox"/>			

Other Pain Questions

Circle the kind of pain you have:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Spreading	<input type="checkbox"/> Aching	<input type="checkbox"/> Deep
<input type="checkbox"/> Dull	<input type="checkbox"/> Superficial	<input type="checkbox"/> Pulsating	<input type="checkbox"/> Burning

Is the pain? Constant Intermittent

Does the pain last for a moment Minutes Hours All day

Does the pain start Suddenly? Gradually

Does the pain stop suddenly Gradually

What time of the day or night is the pain the most severe

How often do you have pain?

What is the longest period you have gone without pain?

What medication(s), if any, do you take to relieve the pain?

Does rest increase or decrease the pain?

Please describe any method of positioning the jaw or head that you have found for relieving pain:

Do any of the following normal daily activities cause pain? If yes, indicate where you feel pain.

<input type="checkbox"/> Yawning	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Brushing	<input type="checkbox"/> Moving shoulders
<input type="checkbox"/> Chewing	<input type="checkbox"/> Speaking	<input type="checkbox"/> Moving head	<input type="checkbox"/> Moving arms
<input type="checkbox"/> Singing	<input type="checkbox"/> Shouting	<input type="checkbox"/> Moving neck	<input type="checkbox"/> Moving trunk



Patient Name: _____ DOB: _____ DOS: _____

DYSFUNCTION

Can you open your mouth normally?	<input type="checkbox"/> Completely	<input type="checkbox"/> Partially
Do you ever open so wide your mouth locks open?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any of these sounds in the joint?	<input type="checkbox"/> Snapping	<input type="checkbox"/> Grating
If you have any of these problems is it frequent?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any change in your bite?		<input type="checkbox"/> Yes <input type="checkbox"/> No

MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS

Are your jaw muscles ever tired?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a jaw thrust habit or nervous twitch about the face?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your face swell?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever noticed production of more saliva or less saliva?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do tears form in your eyes for no apparent reason?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the symptoms start after any of the following conditions?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Severe emotional upset	<input type="checkbox"/> A blow on the jaw	<input type="checkbox"/> Excessively large bite or yawn
<input type="checkbox"/> Traction for cervical whiplash	<input type="checkbox"/> Traction for cervical arthritis	
How long have you been bothered by this problem?		
Have you had any injury to the jaw or face? If yes, explain.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any other treatment for this problem? (If yes, explain-medicine, exercise, dental treatment)		
Have you had your teeth straightened (orthodontia)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sensitive to metal rings or earrings?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had your bite adjusted by your dentist? (If yes, please explain when)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you attribute the symptoms to any one incident?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had cortisone injected into the joint? If yes, when?		<input type="checkbox"/> Yes <input type="checkbox"/> No
How many injections?	By whom?	
Do you know if you clench your teeth?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone mentioned that you grind your teeth (brux) at night during sleep?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you chew gum?	<input type="radio"/> Frequently <input type="radio"/> Moderately <input type="radio"/> Infrequently <input type="radio"/> Never	
Is there anyone else in your family with a similar problem? (If yes, explain)		
Please describe briefly any changes in location or character of symptoms since this problem began		
Please list chronologically names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on the back of the sheet if necessary		

Did any of the treatments make you feel better? If so, which helped the most? In what manner?

Did any of the treatments make you feel worse? Which ones? In what manner?

Please write in any other pertinent information that has not been covered previously.



Dedicated Sleep, LLC Notice of Privacy Practice Effective January 1, 2020

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.

Questions? Please contact our Privacy Office at the address/ phone number at the end of this notice.

Who will follow this notice?

We provide health care to patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All contracted service partners for sleep and DME services.
- Any healthcare professional authorized to enter information into your chart, including practicing physicians and other credentialed individuals that participate with us in providing care and services.
- Any business associate or partner with whom we share health information.

Our Pledge to You:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in order to provide quality care and to comply with legal requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the current notice.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If there is a significant change in our policies, we will change our notice and post the new version in areas of the facilities generally accessible by patients and their families. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you.

- We may use and disclose medical information about you with your consent or with the consent of others who are legally permitted to consent on your behalf for treatment (e.g., sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (e.g., sending billing information to your insurance company or Medicare); and to support health care operations (e.g., comparing patient data to improve treatment methods.)
- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, birth, death, abuse or neglect and domestic reporting, health oversight audits or inspections, qualified research studies, funeral arrangements and organ donation, workers' compensation purposes, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and other emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, e.g., regarding inmates in their custody, or in response to valid judicial or administrative orders.



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- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you,
- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

- In most cases, you or your personal representative have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after your date of service. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.
- All written requests or appeals should be submitted to our Privacy Office listed below:

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office at:

Address: Privacy Office C/O Dedicated Sleep 21260 S. Springwater Road, Estacada Oregon 97023

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.



Acknowledgement 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

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



DEDICATED SLEEP™
SLEEP WELL LIVE WELL

21260 S. Springwater Rd | Estacada, OR 97023
Phone: 800-279-3104 | Fax: 949-798-6979 | dentalinfo@dedicatedsleep.net | dedicatedsleep.net

Medical Records Release Form

Patient's Name: _____ **Date of Birth:** _____

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Dedicated Sleep
21260 S. Springwater Rd
Estacada, OR 97023
Kenneth A Mogell DMD PA
2900 N Military Trl Ste 212
Boca Raton FL 33431

Patient Signature: _____ **Date signed:** _____



Dedicated Sleep



AFFIDAVIT FOR INTOLERANCE TO PAP

Check the following that applies:

I have **NOT** attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and feel it would be intolerable to use for the following reasons (check all that apply below):

HAVE attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons (check all that apply below):

Amount of time PAP was used: _____

- Mask leaks
- An inability to get the mask to fit properly
- Discomfort 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 PAP apparatus at night
- Other (Please describe): _____

Based on my intolerance/inability to use PAP, I wish to have the alternative treatment, oral appliance therapy (OAT).

Patient Name: _____

Signature: _____ Date: _____



Dedicated Sleep



Florida Dental Sleep Disorders
Kenneth A. Mogell D.M.D. A.B.D.S.M.

Name:

Date:

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to assess a person's daytime sleepiness.

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 or sleep.
- 1 = **slight** chance of dozing or sleeping
- 2 = **moderate** chance of dozing or sleeping
- 3 = **high** chance of dozing or sleeping

Situation	Chance of Dozing
Sitting and Reading?	
Watching TV?	
Sitting inactive in a public place (ex: meeting, theater)?	
Being a passenger in a motor vehicle for an hour or more?	
Lying down to rest in the afternoon if 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:	

Thank You!



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Informed Patient Consent

Patient Name: _____ DOB: _____

Welcome! We would like to give you a little more information about ourselves, and what to expect during our TMD treatment or sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY AND PRIVACY NOTICE:

Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

IN CASE OF EMERGENCY, PLEASE CONTACT DEDICATED SLEEP AT (800) 279-3104

Patient

Date

Patient Name _____ Date: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Florida Dental Sleep Disorders appreciates the confidence you have shown in choosing us to provide your treatment. The services you have elected to receive imply a financial responsibility on your part. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know your coverage and benefits.** You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. **If you change insurance it is your responsibility to inform our office.** We are non-participating Medicare providers. We are not providers in Medicare Advantage and are not participating in the managed care network. We will file your claims to Medicare. **If you change to a Medicare Advantage plan you will be responsible for office visit charges.**

I understand that I am responsible for co-payments and deductibles/co-insurance as dictated by my insurance carrier. **Initial:** _____

I understand that I am responsible for obtaining referrals if required by my insurance carrier. Failure to obtain referrals will make me responsible for payment in full. **Initial:** _____

I authorize Florida Dental Sleep Disorders to furnish information to insurance carriers concerning my care for insurance purposes. **Initial:** _____

I fully understand that I am ultimately responsible for all charges associated with my account and that if I fail to pay any amount due I will also be responsible for all charges incurred in the collection of the balance due. **Initial:** _____

Cancellation/No Show. We understand that there may be times when an appointment is missed due to emergency or illness. However, you must call the office prior to your appointment time to cancel or reschedule. Repeated late cancellations may lead to cancellation fees and/or payment in advance for appointment times. **Initial:** _____

Self-Pay patients should be prepared to pay at the time of each visit. **Initial:** _____

I have read the above policy regarding my financial responsibility to Florida Dental Sleep Disorders. I certify that the information given is true and accurate. I authorize my insurer to pay benefits directly to Florida Dental Sleep Disorders, Kenneth A. Mogell, DMD, PA. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

Patient Signature

Date

Print Name



Florida Dental Sleep Disorders

Kenneth A. Mogell, D.M.D.

Diplomate, American Board of Dental Sleep Medicine

General Release of Liability & Assumption of Risk for Obstructive Sleep Apnea

I, _____, understand that due to the nature of sleep medicine 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 Dr. Kenneth A. Mogell and Kenneth A. Mogell, DMD, PA 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 Dr. Kenneth A. Mogell and Kenneth A. Mogell, DMD, PA, and his staff, 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 Dr. Kenneth A. Mogell and Kenneth A. Mogell, DMD, PA and his staff harmless for any issues or damages that might result from my sleep apnea treatment.

Signature _____

Date _____

Please Print Name _____

Witness _____

Date _____

Please Print Name _____

1230 S. Old Dixie Hwy
Jupiter, Florida 33458

2900 N. Military Trail
Suite 212
Boca Raton, Florida 33431
561-353-5252

787 37th Street
Suite 180
Vero Beach, Florida 32960

1400 Pine Street
Suite A
Melbourne, FL 32901



Florida Dental Sleep Disorders

Kenneth A. Mogell, D.M.D.

Diplomate, American Board of Dental Sleep Medicine

INFORMED CONSENT FOR THE TREATMENT OF

OBSTRUCTIVE SLEEP APNEA

Obstructive sleep apnea (OSA) is a medical condition with a dental treatment. For OSA to be treated by a dentist, a diagnosis of OSA must be made by a physician trained in the field of Sleep Medicine. If you have not been diagnosed with OSA by your physician, please understand that Dr. Mogell will not proceed with treatment without a sleep study and a diagnosis of OSA by a physician. Dr. Mogell will work in collaboration with your physician to achieve the best results possible for the treatment of your sleep apnea.

Oral appliance therapy is a very effective treatment. However, no therapy works 100% of the time. The mandibular advancement device (MAD) works by moving the jaw and tongue forward at night which acts to keep the airway open. As with any medical therapy, successful treatment of OSA using dental appliance cannot be guaranteed. Success depends on many things. The most important component of success is patient compliance.

By signing this document, you hereby agree to follow Dr. Mogell's instructions in detail. Failure to do so may well result in a poor clinical outcome.

Obstructive Sleep Apnea (OSA) is an unusual disease because it has been associated with many medical conditions. As a result of OSA, or as a complication of not treating your OSA, patients may develop any or all of the following, temporary or permanent diseases: coronary artery disease; high blood pressure; diabetes; cerebrovascular disease; stroke; heart problems; heart attack; atrial fibrillation; depression; mood disorders; sexual dysfunction; weight gain; obesity; excessive daytime sleepiness; increase work and traffic related accidents; and death.

A number of temporary or permanent dental issues may develop as a result of long term treatment of OSA with a mandibular advancement device (MAD). You should be aware that complications as a result of oral appliance therapy have been minor; however, it is the patient's responsibility to immediately inform Dr. Mogell of any issues which may develop to prevent a permanent condition or complication. Possible complications may include, but are not limited to: jaw joint pain; TMJ dysfunction; headaches; b neck aches; pain on chewing; facial pain; popping and noise in the jaw; sore teeth; worsening of periodontal pockets; loosening of teeth; dry mouth or excessive saliva; fracturing or loosening of dental fillings, crowns or bridges; short term or long term bite changes; spacing or shifting of teeth; tilting of teeth; profile changes; lessening of overbite or over jet; difficulty chewing; oral cysts and oral tumors.

Initial _____

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Jupiter, Florida 33458

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Suite 212
Boca Raton, Florida 33431
561-353-5252

787 37th Street
Suite 180
Vero Beach, Florida 32960

1400 Pine Street
Suite A
Melbourne, FL 32901

844-MY-APNEA

Fax: 561-988-1102

www.fldsds.com



Florida Dental Sleep Disorders

Kenneth A. Mogell, D.M.D.

Diplomate, American Board of Dental Sleep Medicine

After your appliance is placed, it will be adjusted by Dr. Mogell to achieve the best results possible. When your apnea symptoms have improved and, Dr. Mogell is satisfied with the results of the adjustments, you will be referred back to your physician for post-treatment evaluation and a post-treatment sleep study. This evaluation is to insure that your apnea is adequately controlled by the MAD and that no further adjustments or other treatment is needed. Your treatment must be confirmed by an in-lab sleep study and evaluated by your physician after Dr. Mogell completes his adjustments.

Follow-up appointments are required with Dr. Mogell on a 3 month, 6 month, and yearly basis to check the effectiveness of your appliance and the success of your OSA treatment. Failure to maintain these follow-up appointments will constitute a lack of compliance with Dr. Mogell's treatment plan. Any decision on your part to forego follow-up appointments places your health at risk and increases the probability of complications and treatment failure.

Additionally, we strongly recommend recall appointments should be kept with your general dentist on a three month schedule for the first year that you wear a MAD to evaluate your dental hygiene, gums and check for decay.

By signing this consent form you acknowledge that you 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, you are aware that more than one treatment may necessary for the best results.

WHEREFORE: I give my consent for the treatment of my OSA using a mandibular advancement device (MAD). I agree and consent to allow Dr. Mogell and his staff to examine my mouth, teeth, jaw, gums, and associated structures. I give consent for the taking of x-rays, photos, impressions and any other procedures necessary for the treatment of my OSA. I also give consent for a home sleep study, if necessary, for the adjustment of my appliance. I consent for the contents of my record to be shared with my physician and insurance company.

I affirm that I have read this document and have been given adequate information regarding the treatment of my condition to give my informed consent. I understand the proposed treatment of my OSA using MAD therapy and I have been given the opportunity to ask questions. All of my questions have been answered and I am ready to proceed with treatment.

Patient Signature _____ Date: _____

Print Name _____ Date: _____

Witness _____ Date: _____

Print Name _____ Date: _____

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