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

Valued Patient,

Due to OVERWHELMING REQUESTS from our patients for treatment to help alleviate sleep disorders like sleep apnea and snoring, we now offer an FDA approved oral appliance that eliminates or reduces sleep apnea and snoring.

Over 127 clinical trials have been performed confirming that oral appliances can eliminate or reduce sleep apnea. Universities including Harvard Medical School, UCLA School of Medicine, and University of Florida School of Medicine completed these clinical studies. Furthermore, the Department of Health reports that 80% of current CPAP users prefer an oral appliance to their current CPAP to reduce sleep apnea.

Obstructive sleep apnea can be a potentially life-threatening disease. Do you feel tired and sleepy even after a full night’s sleep? Do you snore all night, are a mouth breather, get dry mouth, or feel fatigued the next day? If you have answered yes to any of these, then you are probably suffering from obstructive sleep apnea. Many are unaware that excessive snoring or sleep apnea is a serious health problem that can lead to heart disease, obesity, hypertension, stroke, diabetes and GERD if not treated in time. People with untreated sleep apnea are also 3-5 times more likely to develop cancer and are at an increased risk of dementia (due to hypoxia).

For these reasons we are now providing screenings for your convenience. If you feel you would benefit from this medical screening, then fill out the brief questionnaire below so we can better serve you.

**Do you currently use a CPAP machine? Y N**

**Have you had a sleep study? Y N**

**Which of the following have you experienced?**

|  |  |  |
| --- | --- | --- |
| * Type 2 Diabetes | * Difficulty Concentrating | * High Blood Pressure |
| * Daytime Sleepiness | * Heart Disease | * History of Stroke |
| * Depression | * High Cholesterol | * Restless Leg Syndrome |
| * Heavy Snoring | * Stop Breathing While Sleeping |  |

**In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?**

**0 = Would never doze 2 = Moderate chance of dozing**

**1 = Slight chance of dozing 3 = High chance of dozing**

|  |  |
| --- | --- |
| **Situation** | **Score (0 to 3)** |
| Sitting and reading |  |
| Watching television |  |
| Sitting inactive in a public place (i.e. theater) |  |
| As a car passenger for an hour without a break |  |
| Lying down to rest in the afternoon |  |
| Sitting and talking to someone |  |
| Sitting quietly after lunch without alcohol |  |
| In a car, while stopping for a few minutes in traffic |  |

**Dental Insurance Information**

Patient’s name: DOB: / /

Home Phone:\_\_\_\_ Cell: Work:

Address: City: State: Zip:

Relationship to the insured (please circle): Self Spouse Child Other

Student: YES NO Status: Full-time Part-time

Name of School: City/State:

**Primary Dental Insurance**

Policy Holder: SSN: DOB: / /

Home Phone: Cell: Work:

Address: City: State: Zip:

Employed by: City: State:

Insurance Company: Group #: Phone:

**Secondary Dental Insurance**

Policy Holder: SSN: DOB: / /

Home Phone: Cell: Work:

Address: City: State: Zip:

Employed by: City: State:

Insurance Company: Group #: Phone:

I acknowledge that my insurance policy is a contract between the insured and the employer and accept responsibility for all fees not covered by the insurance company. Details of the insurance plan benefits and limitations are the responsibility of the policy holder and not Oviedo Premier Dental. I further give permission for Oviedo Premier Dental to file insurance claims and accept payments directly from the insurance company on my behalf.

Signature: Date:

**Financial Form**

Thank you for choosing us to provide your dental care. We are committed to providing you with the best possible care and service in a manner that will best suit your needs. We do not want financial considerations to be an obstacle to your care. It is for this reason that different options are available to you.

**PATIENTS WITH INSURANCE:** **As a courtesy,** we will complete and send dental insurance forms for you; however, your insurance policy is a contract between you and your insurance company. If payment has not been received from your insurance within 45 days, we will request payment in full from you. Any overpayment will be returned promptly. We expect payment in full within 15 days of insurance payment unless other arrangements have previously been made. While insurance benefits may be forthcoming, we are careful to make no assumptions about their amount. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions regarding coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

**PATIENTS WITH OR WITHOUT INSURANCE:** We are more than happy to discuss any financing and low monthly payments with you.

**We accept cash as well as Visa, MasterCard, Discover, and American Express, but we do not accept personal checks. If an extended payment plan is desired, please ask us about zero percent financing.**

Balances older than 30 days may be subject to interest charges of 1.5% per month or service charges. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.

I understand and accept responsibility for payment of all services rendered on my behalf and/or my dependents, which includes any amount not paid by insurance benefits. Failing to return to the office for completion of these procedures does not absolve me from being responsible for the full cost of that procedure. In the event that my account becomes delinquent, I am aware I will be responsible for any and all collection fees. I understand that this policy is subject to change. I understand that even if I do not sign this form, and consent to receive treatment, the above guidelines still apply.

Signature: Date:

**Notice of Privacy Practices Acknowledgment**

Oviedo Premier Dental

1445 E. Mitchell Hammock Rd.

Oviedo, FL 32765

407-977-6464

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
* Obtain payment from third-party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If necessary my Protected Health Information may be released to the following person(s):

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If you would like anyone other than yourself to be able to call our office and discuss your account or dental information,

you must print their name in the space provided above. This includes spouses and parents of children over 18.

**Patient Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

|  |  |  |
| --- | --- | --- |
| Date | Initials | Reason |
|  |  |  |