All Smiles Sleep Solutions - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____________________ Last Name: _______________________ MI: ___

Home Phone (_____) ___________ Cell Phone (_____) ____________ Work Phone (_____) ___________

Email Address________________________________

Address: __________________________________City:________________ State: ______ Zip: __________

Date of Birth (M/D/Y): ____ /____ /______ Gender: ☐M ☐ F Social Security Number (SSN): ________________

Height: Feet_____ Inches_____ Weight (lbs): _____ Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Minor

Spouse or Parent/Guardian (if minor) Name: ___________________________________

Emergency Contact: ________________________ Relationship: _____________ Phone__________________

REFERRED BY: ____

Employer Information

Employer: ___________________________________ Phone: ____________ Fax: ____________

Address: _______________________________City______________________ State: _____Zip: _________

Health Insurance Information

Patient's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): _______________________________ Insured DOB (M/D/Y): ____ /____ /_____

Ins Co.: ____ Ins ID: _________________________

Group #: ___________________________________ Plan Name: __________________________________

Business Address________________________________ City________________ State: _____ Zip __________

Phone: ___________________Fax: ___________________ Email: _______________________________

Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): ______________________ Insured DOB___ /___ /_____

Ins Co.: ____ Ins ID: _________________________

Group #: ___________________________________ Plan Name: __________________________________

Business Address________________________________ City________________ State: _____ Zip __________

Phone :_________________ Fax: ___________________ Email: _______________________________

Please present your secondary insurance card so we can photocopy it.

Medical Contacts

All Smiles 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: ______________________

SLEEP DOCTOR: _______________________________________ Phone: ______________________

DENTIST: ____ Phone: ______________________

OTHER MD: ____ Phone: ______________________

OTHER MD: ____ Phone: ______________________

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: ______ Date:_____

All Smiles Sleep Solutions Patient Questionnaire

EPWORTH SLEEPINESS SCALE

Sitting and Reading	___________________
Watching TV	___________________
Sitting inactive in public place (theater)	___________________
As a car passenger for an hour without a break	___________________
Lying down in the afternoon to rest	___________________
Sitting and talking to someone	___________________
Sitting quietly after lunch without alcohol	___________________
In a car while stopped at a traffic light	___________________

0 = No chance of dozing
1 = Slight Chance of dozing
2 = Moderate Chance of dozing
3 = High Chance of dozing

TOTAL = ____________

THORNTON SNORING SCALE

My snoring affects my relationship with my partner	______________
My snoring causes my partner to be irritable or tired	______________
My snoring requires us to sleep in separate rooms	______________
My snoring is loud	______________
My snoring affects people when I am sleeping away from home	______________

0 = Never
1 = 1 night/week
2 = 2-3 nights/week
3 = 4+ nights/week

TOTAL = ____________

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

____

Do you have other complaints?

- ☐ Frequent snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other: ___________________________________
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

Subjective Signs and Symptoms

Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Have you been told you snore? YES / NO / SOMETIMES

Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)

On average, how many times per night do you wake up? ____________________

On average, how many hours of sleep do you get per night? ____________________

How often do you awaken with headaches? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

Do you have a bed partner? YES / NO / SOMETIMES **Do you sleep in the same room?** YES / NO

How many times per night does your bedtime partner notice you stop breathing?

SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER

All Smiles Sleep Solutions Patient Questionnaire

Have you ever had a sleep study? YES NO
If YES, where and when? ____**Date:**____________________

Have you tried CPAP? YES NO
Are you currently using CPAP? YES NO
If YES, how many nights per week do you wear it? _____________/ 7 Nights
When you wear your CPAP, how many hours per night do you wear it? _____________hours per night

If you use or have used CPAP, what are your chief complaints about CPAP?

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort from the straps or headgear
- ☐ Decrease sleep quality or interrupted sleep from CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI / stomach / intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ The device causes irritation due to air leaks
- ☐ Other: ____ ____

Are you currently wearing a dental device? YES NO
Have you previously tried a dental device? YES NO
If YES, was it Over the Counter (OTC)? YES NO
Was it fabricated by a dentist? YES NO **If YES, who fabricated it?** ________________________

If applicable, please describe your previous dental device experience:
____

Have you ever had surgery for snoring or sleep apnea? YES NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: ____________ SURGEON: ______________________ SURGERY: ____
DATE: ____________ SURGEON: ______________________ SURGERY: ____
DATE: ____________ SURGEON: ______________________ SURGERY: ____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.

____
____
____

All Smiles Sleep Solutions Patient Questionnaire

PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures? YES NO
If YES, what medication(s) and why do you require it? ____

ALLERGENS -- Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

_____ ____

MEDICATIONS -- Please list all medications you are currently taking:

____

MEDICAL HISTORY – Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

____
____
____

Dental History

How would you describe your dental health? EXCELLENT GOOD FAIR POOR
Have you ever had teeth extracted? YES NO → **If YES, please describe**___________________
Do you wear removable partials? YES NO
Do you wear full dentures? YES NO
Have you ever worn braces (orthodontics)? YES NO → **If YES, date completed:** ___________________
Does your TMJ (jaw joint) click or pop? YES NO → **Do you have pain in this joint?** YES NO
Have you had TMJ (jaw joint) surgery? YES NO
Have you ever had gum problems? YES NO → **If YES, have you ever had gum surgery?** YES NO
Do you have dry mouth? YES NO
Have you ever had an injury to your head, face, neck, or mouth? YES NO
Are you planning to have dental work done in the near future? YES NO
Do you clench or grind your teeth? YES NO
If you answered YES to any question above, please briefly describe your answer here:

____
____

Family History

Have genetic members of your family had:
Heart Disease? YES NO **High Blood Pressure?** YES NO **Diabetes?** YES NO
Have genetic members of your family been diagnosed or treated for a sleep disorder? YES NO
How often do you consume alcohol within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
How often do you take sedatives within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
How often do you consume caffeine within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
Do you smoke? YES NO **If YES, how many packs per day?** _______________
Do you use chewing tobacco? YES NO **If YES, how many times per day?** ________________

PATIENT SIGNATURE

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.
Patient or Guardian Signature: ____________________________________ Date: ______________

NON DENTIST-OF-RECORD RELEASE FORM

I am seeking treatment with a sleep orthotic appliance only. I understand that I am not a dental patient-of-record with Drs. Joseph and Melissa Grimaudo. The importance of regular dental care has been explained to me and I understand that Drs. Joseph and Melissa Grimaudo 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 Name (Please Print)

Patient Signature   Date

PATIENT MEDICAL RECORD RELEASE FORM

Our office coordinates treatment with your healthcare providers to help ensure maximum benefit to you. Please sign the record release form below so we can retrieve dental radiographs related to sleep disordered breathing.

TO: ____

FROM: Dr. Joseph Grimaudo

We would like to request a copy of the following if applicable:

- **Most recent Panoramic Radiograph.**

PATIENT NAME: ____

PATIENT DOB: ____

We wish to obtain the records in this way:

___ PLEASE FAX TO THE PHONE NUMBER LISTED BELOW

___ PLEASE MAIL TO US AT THE ADDRESS LISTED BELOW

_X__ Send to our Secure Email – info@allsmilessleepsolutions.com

ADDRESS:

Dr. Joseph N. Grimaudo
17200 Camelot Court
Land O Lakes FL 34638
FAX: (813) 920-6712

I request and authorize the above named doctor or health care provider, or individual named in this request to obtain my medical records. A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Patient Signature: _____________________________ Date: __________

Additional Comments:

____

____

Thank you in advance.

All Smiles Sleep Solutions

Joseph N. Grimaudo, DMD ◆ Melissa M. Grimaudo, DMD

PATIENT MEDICAL RECORD RELEASE FORM

Patient name: ______________________________

Birthdate: ______________________________
Address: ______________________________
Telephone: ______________________________

I hereby authorize: ______________________________ **Phone#:** __________

to release records to: All Smiles Sleep Solutions

We would like to request a copy of the following if applicable:

Information to be released:
- All records pertaining to sleep related breathing disorder and progress notes
- Test results
- X-Rays (if available)
- All baseline Polysomnography (PSG's)

Records are needed for:
- Coordinating Care of Oral Appliance Therapy for Obstructive Sleep Apnea
- Insurance
- Continuing care
- Other ______________________________

PLEASE FAX INFORMATION TO: 813-920-6712

I request and authorize the above named doctor or health care provider, or individual named in this request to obtain my medical records. A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Signature ______________________________

Date

This message is from All Smiles Sleep Solutions and is intended solely for the individual or entity named above. Access by anyone else is unauthorized. The information contained herein may include confidential information that is protected by federal and state laws. If you are not the intended recipient, unauthorized review, forwarding, printing, copying, distributing or using such information is strictly prohibited and may be unlawful. If you received this message in error, or have reason to believe you are not authorized to receive it, promptly notify All Smiles Sleep Solutions at info@allsmilessleepsolutions.com or 813-345-8580. Thank you.

17200 Camelot Court ◆ Land O'Lakes, FL 34638 ◆ (813)345-8580

www.allsmilessleepsolutions.com ◆ info@allsmilessleepsolutions.com

All Smiles Sleep Solutions Patient Notices

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 feasor 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.

I understand that All Smiles Sleep Solutions will communicate with me and / or my family member by email, phone call or text. This communication can include HIPAA information including treatment details and financial arrangements.

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: Dr. Melissa Grimaudo or Dr. Joseph N. Grimaudo, 17200 Camelot Court Land O Lakes FL 34638

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature:

Print Name:

Patient / Guardian Signature: **Date**:

All Smiles Sleep Solutions
Custom Dental Sleep Appliances

Joseph N. Grimaudo, DMD ◆ Melissa M. Grimaudo, DMD

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? 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

________ Sitting and reading

________ Watching TV

________ Sitting, inactive in a public place (e.g. a theatre or a 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 a lunch without alcohol

________ In a car, while stopped for a few minutes in the traffic

Have you ever been told you stop breathing while asleep?

Have you ever fallen asleep or nodded off while driving?

Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?

Do you feel excessively sleepy during the day?

Do you snore or have you ever been told that you snore?

Have you had weight gain and found it difficult to lose?

Have you taken medication for, or been diagnosed with high blood pressure?

Yes/No	Do you kick or jerk your legs while sleeping?
Yes/No	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Yes/No	Do you wake up with headaches during the night or in the morning?
Yes/No	Do you have trouble falling asleep?
Yes/No	Do you have trouble staying asleep?
Yes/No	Have you ever used a CPAP before?

Please check any conditions for which you have been medically diagnosed or treatment.

______ Heart Failure	______ Stroke
______Hypertension	______ Diabetes
______ Metabolic Syndrome	______ Obesity
______ Heartburn (Gastroesophageal Reflux)	______ Atrial Fibrillation

AFFIDAVIT FOR INTOLERANCE TO CPAP

Check the following that apply:

I have **NOT** 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 reasons:

Latex allergy

Claustrophobic associations

Other____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Print Name: ____

Signature: ____ Date: ___________________

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 reasons:

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 my 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 CPAP apparatus at night

Other____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Print Name: ____

Signature: ____ Date: ___________________

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