Better Sleep Eugene
Oral Appliance Therapy Patient Intake

Date: _____

Patient Name:_____ Date of Birth:_____

Gender: M/ F /Nonconforming Home Phone:_____ Cell:_____ Work:_____

Email:_____

Address:_____

City:_____ State:_____ Zip:_____

Height:_____ Weight:_____ Neck Circumference: _____BMI:_____

BP:_____ Pulse:_____

Primary Care Physician:_____ Phone Number:_____

Type of Medical Insurance: Medicare HMO PPO Tricare Other N/A

Name of Insurance:_____ Member ID #:_____

Group #: Insurance Phone #

Have you been Diagnoses with the following?

Obstructive Sleep Apnea: Yes / No

Loud Snoring: Yes / No **High Blood pressure:** Yes / No **Heart disease:** Yes / No **Stroke:** Yes / No

Diabetes: Yes / No **Thyroid:** Yes / No **Insomnia:** Yes/ No **Depression:** Yes / No **COPD:** Yes / No

Morning Headache: Yes / No **Restless Leg Syndrome:** Yes / No **Night time Urination:** Yes / No

Epworth Sleepiness Questionnaire

Use the following scale to choose the most appropriate # for your situation.

0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Sitting and reading	**0**	**1**	**2**	**3**
Sitting quietly in a public place	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting quietly after lunch w/o alcohol	**0**	**1**	**2**	**3**
As a passenger in a car not stopping to stretch	**0**	**1**	**2**	**3**
In a car while stopped in traffic for a few minutes	**0**	**1**	**2**	**3**
Laying down to rest in the afternoon	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**

_____ Total Score

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of $5 per month on the unpaid balances will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Acknowledgement of Receipt of Statement of Privacy Practices

Acknowledgment of Receipt of Statement of Privacy Practices I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Ivan P Paskalev, DMD, PC. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of services or in performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy practices is also posted in the facility and online at www.MyGreat.Dentist . Ivan P Paskalev, DMD, PC reserves the right to change the privacy policies currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me. In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

☐ Spouse only ☐ Any member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)

☐ Any Member of my extended family: (i.e. Parents, Grandchildren)

Please select at least one option from the list

Signature:_____ Date:_____

If Patient's Representative is signing, please provide name:
Relationship: