CENTER FOR
DENTAL SLEEP MEDICINE & TMJ
OF NEW MEXICO

: 505.433.2107
: 505.508.2674
: www.centersleeptmj.com
: smile@centersleeptmj.com

Patients name: _____

Appointment date: _____

Dear new patient:

Welcome to our practice and thank you for giving us the opportunity to evaluate and manage your Sleep Apnea and TMJ needs. For your convenience we are enclosing some forms and information to prepare you for your first visit.

Please complete the Registration Form and Medical Questionnaire and read and sign the Financial Policy. In addition to those forms, you will need to bring your medical insurance card(s).

Here is a review of all the things you will need to make your first visit go smoothly. We hope you find this helpful.

First visit checklist:

- Registration Form Completed
- Medical Questionnaire Completed
- Financial Policy Read and Signed
- Medical Insurance Card(s)

Like most health care practices, it is imperative that you arrive on time for your appointment. If you need to reschedule, please give 24 hours notice. If you have any other questions please do not hesitate to contact us at (505) 433-2107. Thank you again for this opportunity. We look forward to meeting you.

Sincerely,

Kinnari Jariwala, DDS

Today's Date: _____

Patient's First Name: _____ MI: _____ Last Name:_____

Responsible Party (if someone other than patient): _____

Address: _____ Apt #_____ State: ____ Zip: _____

Home Phone #_____ Cell #_____Work # _____

Okay to leave message regarding health information on voicemail? If yes, initial:

Patient's SS#:_____ DOB: _____ Age: _____ Sex: _____

Marital Status: _____ E-Mail Address: _____

If patient 18years or over and insured by parent: Is patient a student? Yes No

If patient is a minor:

Parent's or Guardian's full name: _____ Relationship:_____

Family Dentist: _____ Dentist's Phone: _____

Family Physician: _____ Physician's Phone: _____

Referred by: _____ Phone: _____

Please tell us about your insurance coverage. Complete all fields:

MEDICAL INSURANCE

PRIMARY: Name of Insurance Company: _____

Policy Holder's Name: _____SSN:_____ DOB: _____

Policy Holder's Employer: _____ ID# _____

Relationship to Patient: _____

SECONDARY: Name of Insurance Company: _____

Policy Holder's Name: _____SSN:_____ DOB: _____

Policy Holder's Employer: _____ ID# _____

Relationship to Patient: _____

INJURY OR TRAUMA

Name of Workers Comp Or Auto Ins. Company: _____

Case Worker's Name: _____Claim#: _____

Phone #: _____ Employer: _____

Date of Injury: _____

MEDICAL QUESTIONNAIRE

NAME: _____ DOB:_____ TODAY'S DATE_____

ALLERGENS

_____No Known allergies
_____ Local anesthetic
_____Sleeping pills
_____Codeine
_____Iodine
_____Barbiturates
_____Latex
_____Aspirin
_____Penicillin
_____Plastic
_____Metal
_____Antibiotics
_____Sulfa drugs
_____Sedatives

MEDICATION	DOSAGE/FREQUENCY	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGICAL OPERATIONS

_____Appendectomy
_____Back surgery
_____Ear
_____Gallbladder
_____Heart surgery
_____Hernia repair
_____Lung
_____Nasal
_____Thyroid
_____Tonsillectomy
_____Uvulectomy
_____Periodontal
Other: _____
_____

FAMILY HISTORY

_____Cancer
_____Diabetes
_____Heart disease
_____High blood pressure
_____Obesity
_____Sleep disorder
_____Stroke
_____Thyroid disorder
_____Father snores
_____Father has sleep apnea
_____Mother snores
_____Mother has sleep apnea

SOCIAL HISTORY

Tobacco Use:
_____Cigarettes
_____Never smoked
_____Current smoker
# of Packs per day: _____
# of years: _____
_____Quit smoking
When did you quit?: _____
Other: tobacco
_____Pipe _____Cigar _____Snuff _____Chew

Alcohol use
_____None
_____Wine
_____Beer
_____Liquor
Drinks per week: _____

Caffeine intake
_____None
_____Coffee
_____Tea
_____Soda
Cups per day? _____

MEDICAL HISTORY

_____Acid reflux
_____Anemia
_____Artherosclerosis
_____Arthritis
_____Asthma
_____Autoimmune disorder
_____Bleeding easily

_____Blood pressure-High
_____Blood pressure-Low
_____Bruising easily
_____Cancer
_____Chemotherapy
_____Chronic fatigue
_____Chronic pain

_____COPD
_____Coronary heart disease
_____Current pregnancy
_____Depression
_____Diabetes
_____Difficulty sleeping
_____Dizziness
_____Emphysema
_____Epilepsy

_____Excessive Daytime Sleepiness
_____Fibromyalgia
_____Glaucoma
_____Gout
_____Heart attack
_____Heart murmur
_____Heart pacemaker
_____Heart valve replacement
_____Hemophilia
_____Hepatitis
_____Hypertension
_____Hypoglycemia
_____Immune system disorder
_____Insomnia
_____Ischemic heart disease (reduced blood supply)
_____Kidney problems
_____Liver disease
_____Meniere's disease
_____Mitral valve prolapse
_____Mood disorder
_____Multiple sclerosis
_____Muscular dystrophy
_____Nasal allergies
_____Neuralgia

_____Osteoarthritis
_____Osteoporosis
_____Parkinson's disease
_____Prior orthodontic treatment
_____Radiation treatment
_____Rheumatic fever
_____Rheumatoid arthritis
_____Sinus problems
_____Sleep apnea
_____Stroke
_____Tendency for ear infections
_____Thyroid disorder
_____Tuberculosis
_____Tumors
_____Urinary disorder
Other: _____
_____

SLEEP HISTORY

CHIEF COMPLAINT

_____CPAP intolerance
_____Daytime tiredness
_____Difficulty falling back to sleep
_____Decrease concentration
_____Gasping causing waking up
_____Awaking unrefreshed
_____Difficulty concentrating
_____Insomnia
_____Excessive Daytime Sleepiness
_____Fatigue

_____Forgetfulness
_____Nighttime choking spells
_____Told you stop breathing during sleep
_____Frequent snoring which affects the sleep of others
_____Never feel rested
_____Frequent nighttime urination
_____Sleepiness while driving
_____Not dreaming
_____Impaired cognition

_____Morning headaches
_____Acid reflux
_____Obesity/weight gain
_____Lack of energy
_____Bruxism (grinding teeth)
_____Dry mouth
_____Restless legs
_____Waking up multiple times a night
How many? _____

Have you previously been diagnosed with obstructive sleep apnea?

When?_____ Sleep Study Date: _____

PAP INTOLERANCE

Complete if you have attempted treatment with a PAP device, but could not tolerate it please fill in this section:

_____Mask leaks
_____Inability to get proper fit
_____Discomfort caused by straps/headgear
_____Interrupted sleep
_____Restricted movements
_____Does not seem to be effective
_____Latex allergy
_____An unconscious need to remove while sleeping
_____Claustrophobic associations
_____Noisy/interrupts bed partner
_____How many masks have you tried?
Other: _____

CONSERVATIVE THERAPY ATTEMPTS:

Even if you have not been diagnosed, how have you tried to help yourself?

_____Diet
_____Surgery
_____Weight loss
_____Over the counter medications
_____Smoking cessation
_____Nasal/snore strips
_____Nasal sprays
_____Pillar implants
_____Avoidance of sleeping on back
_____UP3 surgery
_____Prescription sleep aids
_____Tonsillectomy
_____Positive airway pressure machine
Other:_____
_____

I have attempted to use PAP therapy to manage my sleep related breathing disorder and find it intolerable for the above reasons. Because of my intolerance/inability to use PAP, I wish to have my OSA treated by Oral Appliance Therapy.

Patient Signature: _____ Date: _____

SNORING

How Often? _____Daily _____Often _____Never

Severity? _____Light _____Moderate _____Loud

WITNESSED APNEAS

_____Worse when sleeping on your back _____Worse following alcohol late at night

I certify that the medical history information is complete and accurate:

Patient Signature:_____ Date: _____

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THE EPWORTH SLEEPINESS SCALE

Name: _____ Today's date: _____

Date of birth: _____

How likely are you to doze off or fall asleep in the situations listed below, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't 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

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation	**Chance of dozing (0–3)**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive, in a public place (for example, in a movie theatre or meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon, when permissible	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a meal without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
Total	_____

The Epworth Sleepiness Scale (ESS) was developed in 1990 by Dr. Murray Johns of Melbourne, Australia. He was the first person in Australia to earn a Ph.D. in sleep medicine and the first to start a private practice focused on sleep medicine. His interest in drowsiness led him to create the ESS. Since then, it's become a worldwide standard method for measuring a person's inclination to sleep during the day.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2023, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in fact. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. for example, we may send claims to your medical health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representatives: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to Food and Drug administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activity; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert serious threat to health or safety; and to comply with workers compensation or similar programs.

Descendants: We may disclose health information about a descendant as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page, and $30 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation for our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law. We must comply with a request to restrict a disclosure of protected health information to a health point for purposes of carrying out payment or healthcare operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact officer: Kinnari Jariwala, DDS Telephone: 505-433-2107 Fax: 505-508-2674

E-mail: smile@centersleeptmj.com Address: 8311 Saint Pedro Dr. NE Suite 2, Albuquerque, NM 8711

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Acknowledgement of Receipt of Notice of Privacy Practices (NOPP)

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this offices notice of privacy practices.

Print Name: _____

Signature: _____ Date: _____

Office Use Only

We tempted 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): _____

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

I hereby authorize the use and disclosure of individually identifiable medical/dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected HIPAA privacy regulations.

Specific Description of Information to Be Used or Disclosed: Medical and Dental health history, Clinical and Imaging Study Findings, Treatment Plan, Progress Report and Completion of Treatment.

Purpose for Disclosure: To keep your health care providers informed of your treatment.

I authorize the following person(s) to keep the requested use or disclosure of the above health information:
Doctor and Staff at Center for Dental Sleep Medicine & TMJ of NM

Person(s) Receiving My Authorized Information Include (Fill in Names):

- ☐ Parent/Spouse/Relative _____
- ☐ Referring Provider _____
- ☐ Primary Care Doctor _____
- ☐ Orthodontist _____
- ☐ Other Consultants _____

_____

I understand that I may revoke this authorization at any time by notifying the Center for Dental Sleep Medicine & TMJ of NM in writing. If I choose to do so, my revocation will not affect any actions taken by the Center for Dental Sleep Medicine & TMJ of NM before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

☐ I **do not** authorize Dr. Kinnari Jariwala or affiliates to release any medical information.

This Authorization Expires on ☐ Continue Indefinitely ☐ Effective Only Until _____ (date)

Signature of Patient or Patients Personal Representative

_____ Date _____

If Personal Representative: Print Name: _____

Signature _____ Relationship to Patient_____

For office use only: Copy of signed authorization provided to the individual: Date_____ Initials _____

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Financial Policy

We are pleased that you have chosen **Center for Dental Sleep Medicine & TMJ of NM** for the evaluation and management of your Sleep Apnea or TMJ needs. We hope that your experience here will be exceptional. We strive to communicate clearly and effectively with you in all aspects of your care. We have created this policy so that you understand our expectations regarding insurance and payment for services. If you have any questions, please address those to the receptionist or office manager before you sign the acknowledgement.

1. Forms of Payment: Payment for services is expected the same day services are performed. For your convenience, we accept Visa, MasterCard and American Express, in addition to cash, checks, and money orders. You will be responsible for paying a $25 fee for returned checks. "Care Credit" and "Sunbit" are also available for interest free financing that allows payment over six months. Please ask our front desk staff about these payment options.

2. Covered and Non-covered Services: Appliances are not covered by dental insurance period however some medical policies will cover them if they are prescribed by a physician on your plan. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Insurance Benefits: We will be happy to file your insurance claims as an added service to you. However, it is important that you understand that your insurance company does not share financial responsibility for your bill. Unless you are insured by a federal or state funded program you are responsible for all charges if your insurance company fails to pay.

5. Pre-Authorizations/ Pre-Certifications: We will be happy to attempt to get the service pre-authorized. If the insurance company denies the service, we will notify you. If you have a question concerning your benefits you should direct those to your insurance company.

6. Patient Portion vs. Insurance Portion: Before a service is performed, we will attempt to estimate the portion of the service that your insurance company will not cover. We will notify you of that portion either orally or in writting and you will be expected to pay your estimated portion on or before the service date. For delivery of appliances, your estimated portion will be due on or before the delivery visit. As mentioned above, the insurance portion is estimated and is never a guarantee of payment even after an authorization has been obtained (except for state and federal funded programs). Ultimately, your bill is your responsibility regardless of insurance benefits.

7. Denied or Unpaid Insurance Claims: We will do our best to work with your insurance company to receive reimbursement for your services. However, if an insurance company does not remit payment within 120 days of the service date. For this reason, we encourage you to communicate with your insurance company about your outstanding claims. Additionally, if the insurance company denies payment on a service, and our attempts to appeal the denial fail, you are responsible for the balance. Unfortunately, this sometimes happens even after the service has been pre-authorized.

8. Financial Arrangements: In the event of financial hardship, optional payment arrangements may be discussed with the office staff before the planned date of the procedure or surgery. Since the doctor's main focus is on your health and treatment, they are unable to discuss fees or payment arrangements with you. If alternate arrangements are not requested and agreed upon before the date of the procedure, full payment of the patient's estimated portion will be due, as detailed in this policy.

9. Cancellation of Appointments: In fairness to other patients and the doctor, we require 24 hours notice if you must cancel an appointment. We reserve the right to charge a $50 fee for missed appointments without 24 hour notification.

Thank you again for entrusting us with your care. If you have any questions about this policy or something not addressed in the policy, do not hesitate to ask a member of our office staff.

ASSIGNMENT OF INSURANCE BENEFITS I hereby assign all dental and medical benefits to **Center for Dental Sleep Medicine & TMJ of NM** and authorize the release of medical information to insurance company(s), when requested or necessary. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original.

AGREEMENT WITH FINANCIAL POLICY I will pay for services rendered on the date of service. I have read and agree to the above financial policy. I understand that I am ultimately responsible for all fees for services provided to me.

THIS IS NOT A CONTRACT NOR AN AGREEMENT TO SEEK TREATMENT

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Patient's Name (Printed): _____

Signature: _____Date_____