



# THE EPWORTH SLEEPINESS SCALE

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

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Total Score: _____</p> <p><i>(Add columns 0-3)</i></p>
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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

# Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height \_\_\_\_\_ age \_\_\_\_\_

weight \_\_\_\_\_ male/female \_\_\_\_\_

2. Do you snore?

- yes
- no
- don't know

**If you snore:**

3. Your snoring is?

- slightly louder than breathing
- as loud as talking
- louder than talking
- very loud. Can be heard in adjacent rooms

4. How often do you snore?

- nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- never or nearly never

5. Has your snoring ever bothered other people?

- yes
- no

6. Has anyone noticed that you quit breathing during your sleep?

- nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- yes
- no

If yes, how often does it occur?

- nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- never or nearly never

10. Do you have high blood pressure?

- yes
- no
- don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI > 30  (BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Berlin

# Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center?  Yes  No

If Yes:

Sleep Center Name \_\_\_\_\_  
and Location \_\_\_\_\_

Sleep Study Date \_\_\_\_\_

## FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of:  *mild*  
 *moderate* obstructive sleep apnea  
 *severe*

The evaluation showed an RDI of \_\_\_\_\_ and an AHI of \_\_\_\_\_

## CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: \_\_\_\_\_

## Other Therapy Attempts

What other therapies have you had for breathing disorders?  
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## List any medications which have caused an allergic reaction:

- Y  N Antibiotics  
 Y  N Aspirin  
 Y  N Barbiturates  
 Y  N Codeine  
 Y  N Iodine  
 Y  N Latex  
 Y  N Local anesthetics

- Y  N Metals  
 Y  N Penicillin  
 Y  N Plastic  
 Y  N Sedatives  
 Y  N Sleeping pills  
 Y  N Sulfa drugs

Other allergens:

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## List any medications you are currently taking:

- Y  N Antacids  
 Y  N Antibiotics  
 Y  N Anticoagulants  
 Y  N Antidepressants  
 Y  N Anti-inflammatory drugs  
     (non-steroid)  
 Y  N Barbiturates  
 Y  N Blood thinners

- Y  N Codeine  
 Y  N Cortisone  
 Y  N Diet pills  
 Y  N Heart medication  
 Y  N High blood pressure medication  
 Y  N Insulin  
 Y  N Muscle relaxants  
 Y  N Nerve pills

- Y  N Pain medication  
 Y  N Sleeping pills  
 Y  N Sulfa drugs  
 Y  N Tranquilizers

Other current medications:

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## Medical History

- Y  N Anemia  
 Y  N Arteriosclerosis  
 Y  N Asthma  
 Y  N Autoimmune disorders  
 Y  N Bleeding easily  
 Y  N Chronic sinus problems  
 Y  N Chronic fatigue  
 Y  N Congestive heart failure  
 Y  N Current pregnancy  
 Y  N Diabetes  
 Y  N Difficulty concentrating  
 Y  N Dizziness  
 Y  N Emphysema  
 Y  N Epilepsy  
 Y  N Fibromyalgia  
 Y  N Frequent sore throats  
 Y  N Gastroesophageal Reflux  
     Disease (GERD)  
 Y  N Hay fever  
 Y  N Heart disorder  
 Y  N Heart murmur  
 Y  N Heart pounding or beating  
     irregularly during the night

- Y  N Heart pacemaker  
 Y  N Heart valve replacement  
 Y  N Heartburn or a sour taste  
     in the mouth at night  
 Y  N Hepatitis  
 Y  N High blood pressure  
 Y  N Immune system disorder  
 Y  N Injury to  
      Face  Neck  
      Head  Mouth  Teeth  
 Y  N Insomnia  
 Y  N Irregular heart beat  
 Y  N Jaw joint surgery  
 Y  N Low blood pressure  
 Y  N Memory loss  
 Y  N Migraines  
 Y  N Morning dry mouth  
 Y  N Muscle spasms or  
     cramps  
 Y  N Needing extra pillows to  
     help breathing at night  
 Y  N Nighttime sweating

- Y  N Osteoarthritis  
 Y  N Osteoporosis  
 Y  N Poor circulation  
 Y  N Prior orthodontic treatment  
 Y  N Recent excessive weight  
     gain  
 Y  N Rheumatic fever  
 Y  N Shortness of breath  
 Y  N Swollen, stiff or painful  
     joints  
 Y  N Thyroid problems  
 Y  N Tonsillectomy (have had)  
 Y  N Wisdom teeth extraction

Other medical history:

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



**FINANCIAL POLICY**  
**ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE**

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services and/or co-payments is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Co-payments are the percentage that the insurance company won't pay, generally between 30-50% and it will be collected at the time services are rendered. We accept cash, checks, MasterCard, Visa and Discover. We will be happy to help process your insurance claim-form.

Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable.  
This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, or allowances, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you do have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

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PATIENT SIGNATURE

Date

Dental Center of Naperville

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

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

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dental Center of Naperville  
Telephone: Hitesh K. Patel, D.D.S.  
E-mail: 1060 E. Ogden Ave.  
Address: Naperville, IL 60563

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

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

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

# ACKNOWLEDGEMENT OF RECEIPT 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}

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### For Office Use Only

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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)

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**REVOCACTION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Hitesh K. Patel D.D.S.

## NOTICE OF PRIVACY PRACTICES

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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.

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### 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 (MM/DD/YR), 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

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

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. 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.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, 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 effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** 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.

**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.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**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).

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## **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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.\_\_\_\_ for each page, \$\_\_\_\_ per hour for staff time to locate and 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 of 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**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, or 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 at the end of this Notice. 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.