Beautiful Lake Ridge Smiles
Lake Ridge Ortho-TMJ-Sleep Centre

Patient Information

Patient Name: ______________________ Date: __________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ______________ Birth Date: ______________

Phone (Home): __________ (Work): __________ Ext: _____ (Mobile): __________

E-Mail Address: ______________________

Address: ______________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________ Reason for this visit: ______________

Have you ever had or have any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Allergy to other medications__________
____
☐ Heart Murmur
☐ Hear Disease
☐ Mitral Valve Prolapse
☐ Hepatitis
☐ High Blood Pressure
☐ Excessive Bleeding
☐ Artificial Joints
☐ Diabetes
☐ Anemia
☐ Arthritis

☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Latex Allergy
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Halitosis/Bad Breath
☐ Hay Fever
☐ Head Injuries
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders

☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

☐ Scarlet Fever
☐ **Snore**
☐ **Difficulty Sleeping**
☐ **Headaches**
☐ **Earaches**
☐ **Neck Pain**
☐ **Jaw Pain**
☐ **Allergies**
☐ **Nasal Obstruction**

Other: __________

Is antibiotic Pre-medication needed before any dental work? **(Yes / No)**

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________
- Name of Physician: ______________________ Phone: __________
- Are you currently taking any medications? ☐ Yes ☐ No If yes, which ones?______________________
  ____
- Are you currently taking a blood thinner? ☐ Yes ☐ No If yes, which one? ______________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________ Date:__________
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext:______ Best time to call: ____________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________
Street City State Zip Code

Dental Insurance Information

Primary Insurance

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No

Insurance Plan Name and Address ______________________________

____

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________

Secondary Insurance

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No

Insurance Plan Name and Address ______________________________

____
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

Medical Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Insurance Plan Name and Address ______________________

____

Insurance Phone number ______________________

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________
Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________

New Patient Discovery

What do you want to do with your mouth? ***(Are you looking for function or cosmetics?)***

____

____

What do you like or dislike about your smile? (***ie Whiter, Close Spaces, Crowding***)

____

____

When was your last visit to the dentist?

____

What dental problems are you currently experiencing and how do these problems affect you?

____

____

How often do you brush your teeth and how often do you floss?

____

Do your gums bleed when you brush and floss? ______________________

____

The above statements are true to the best of my ability.

______________________ Date: __________
Signature of patient, parent or guardian

FINANCIAL POLICY
Beautiful Lake Ridge Smiles and
Lake Ridge Ortho-TMJ-Sleep Centre

Dear Patient:

Thank you for choosing us as your dental care provider. The following is our Financial Policy. Therefore, if you have any questions or concerns about our payment policies, do not hesitate to ask our front desk personnel.
We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, and for your convenience, MC, Visa, and American Express. We also offer a payment plan through Care Credit. You may fill out an application and we will process it while you wait.

Upon our verification of your benefits, we will be happy to process your insurance benefits. However, you must understand that:

1) Your out of network insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2) All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

3) Fees for services that are not covered, along with unpaid deductibles and co-payments are due at the time of treatment.

4) If your insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.

5) If the insurance company does not pay in full within 45 days, we require you pay the balance due with cash, check, credit card, or Care Credit.

6) Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 1.5% per month.

7) By signing this form I am acknowledging that I have been made aware that our office is not contracted with any dental carrier, with the exception of Cigna Dental PPO, MetLife PPO, Delta Dental Premier, Aetna PPO, and I am subject to **Balance Billing** for any and all remaining balance after my insurance carrier(s) claims have been filed and processed. We do not accept any DHMO nor Medicaid dental plans.

Please call our office at least 24 hours in advance if you need to reschedule an appointment. Please note that, unless canceled at least 24 hours in advance, you will be charged $55.00 per hour for missed appointments.

Signature on File:

By signing this form I hereby authorize and direct payment of the dental or medical benefits otherwise payable to me, to pay directly to Dr. Carlos G Wiesse and/or Beautiful Lake Ridge Smiles.

Signature on File ________________________________ Date ____________

Periodontal Policy
Beautiful Lake Ridge Smiles
Lake Ridge Ortho-TMJ-Sleep Centre

Dear Valued Patient,

The American Dental Association endorses a program for the detection of periodontal disease. Our hygienist is a specialist in this area. Our examination procedure includes a process for early detection of gum disease. Early detection makes it easier to treat and control. Our hygienist will begin by examining your gums. She will gently use a ruler type instrument to measure any pockets that may exist between the tooth and gum, screen for inflammation and bleeding. If she discovers areas in the mouth which are tender or bleeding then this usually indicates less than healthy tissue.

Upon completion of the exam, the hygienist will put you in one of **five ADA categories**:

- **0 Healthy Mouth**
- **1 Gingivitis**
- **2 Early Periodontitis**
- **3 Moderate Periodontitis**
- **4 Advanced Periodontitis**

Any classification other than a category 0 will take you out of the Healthy category and therefore a regular cleaning is not possible. This may change what your insurance covers.

Fortunately for our patients, Healthcare is constantly improving techniques and procedures in order to prevent and treat our patients properly and avoid surgery or possible tooth loss. Unfortunately, some insurance companies/employers are not keeping up with the improvements and are not covering certain procedures.

We, as your concerned providers understand this and will work with you as much as possible. Your oral health is important to us and we want to provide you with the absolute best treatment necessary.

Please feel free to discuss any questions or concerns about your insurance with the front office staff members, and any questions or concerns about your diagnosis with our hygienist.

Sincerely,

Carlos G. Wiesse, DDS, FAACP, FAGD

Patient Signature:____________________ Date:________

Beautiful Lake Ridge Smiles
Lake Ridge Ortho-TMJ-Sleep Centre

INFORMED CONSENT FOR NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act (HIPPA), I have certain rights of 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 involve in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.

*Obtain payment from third-party payers (dental or medical insurances).

*Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand 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.

I authorize **Beautiful Lake Ridge Smiles** and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and dental services.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list any other parties who can have access to your dental and or medical information:

Name:_______________________________ Relationship:_____________________

Name:_______________________________ Relationship:_____________________

Name:_______________________________ Relationship:_____________________

I have been informed and consent to these notices and release information to the above person(s)

Patient Name:____________________________________

Patient/Guardian Signature:___________________________ Date:_______________

A copy of our office **Notice of Privacy Practices is available upon request**

NOTICE OF PRIVACY PRACTICES

For the practice of Beautiful Lake Ridge Smiles

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer, Carlos G. Wiesse, DDS **at** (817) 649-8888.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your dentist, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your dentist's practice.

Following are examples of the types of uses and disclosures of your protected health information that your dentist's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other dentists who may be treating you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another dentist or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your dentist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your dentist.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your dentist, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your dentist created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Under State law, we are required to notify you of any unauthorized electronic disclosure of your protected health information. Uses and disclosures of your protected health information, whether electronic or printed, will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your dentist may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Under Texas law, you have the right to request an electronic copy of your patient records. We must provide the records to you within 15 days of your request.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your dental record that contains dental and billing records and any other records that your dentist and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your dental record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members, friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If your dentist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your dentist. You may request a restriction by contacting our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your dentist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your dental record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule), or correctional facilities as part of a limited data set disclosure. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us, to the State Attorney General's office, or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (817) 649-8888 for further information about the complaint process.

This notice was published and became effective on 11/01/2013.

Practice name: Beautiful Lake Ridge Smiles

Privacy Officer Name: Carlos G. Wiesse, DDS

Date: ______________________________

This Template (PrivacyPractices 1 14 13) has been provided by Smart Training LLC as an example and is based solely on Smart Training LLCs current research and understanding of PHI regulations. Smart Training is not liable for any actions against any company or organization that chooses to use this template. Use of this template is at users own discretion.

SLEEP EVALUATION / CLINICALS

Patient Name: ______________________________ Date of Birth: ____/____/____

Gender: M ____ F ____ Height: ________ Weight: ________ Blood Pressure: ____________

Please check any of the following you may have:

☐ Diabetes	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night	☐ Heart Failure	☐ Depression	☐ Overweight
☐ Erectile Dysfunction	☐ Morning Headaches	☐ ADHD	☐ Hypertension
☐ Atrial Fibrillation	☐ Renal Failure	☐ Chronic Pain	☐ GERD

Please check Yes or No to the following questions:

1. Do you snore *or* have been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered Yes to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never doze off	Slight chance of dozing	Moderate chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place?	0☐	1☐	2☐	3☐
4. As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5. Lying down to rest in the afternoon?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			Total Score	

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP? (or any other apnea/snoring device)	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you currently taking any prescribed narcotic medication?	☐ YES	☐ NO

Untreated Sleep Disorders are related to many health *and* financial complications:

*Diabetes *Premature death *5X the risk of heart attack *2X the risk of stroke *Weight gain *6X the risk of a serious automobile accident *Increased risk of cancer *Hypertension *Depression *Erectile dysfunction *Daytime fatigue *ADHD *GERD *Decreased job performance *RLS/PLM *Increased cost of healthcare *Chronic/migraine headaches *Post-surgical complications/death *Chronic pain *Weakened immune system *Renal failure *Heart disease

Provider Signature/Initials*______________________________ Today's Date: ____________

*To be filed for reference and review in patient's chart notes