









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 of recent radiographs, we will fulfill your request free of charge. However, if you require any further chart history or a summary of your dental information, we will charge you \$25.00 for staff time to process this request. Contact us using the information listed at the end of this Notice for a full explanation of this policy.)

**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.

Contact Officer: Susan Hedlund \_\_\_\_\_

Telephone: (248) 656-2020 \_\_\_\_\_ Fax: (248) 656-2559 \_\_\_\_\_

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

Address: 433 W. University Rochester, Mi, 48307 \_\_\_\_\_





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

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

# Sleep Center Evaluation

Have you had an evaluation at a sleep center?      Yes      No

If yes: Center name: \_\_\_\_\_

Location: \_\_\_\_\_ Study date: \_\_\_\_\_

**For Office Use Only**

The evaluation confirmed a diagnosis of: Mild   Moderate   Severe   OSA

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

**CPAP Intolerance (Continued Positive Airway Pressure device)**

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

I could not tolerate CPAP device due to:

- |   |   |
|---|---|
| <input type="checkbox"/> Mask leaks                                   | <input type="checkbox"/> I was unable to get mask to fit properly         |
| <input type="checkbox"/> Discomfort caused by straps and headgear     | <input type="checkbox"/> Disturbed sleep caused by the presence of device |
| <input type="checkbox"/> CPAP restricted movement during sleep        | <input type="checkbox"/> Noise from the device disturbing sleep           |
| <input type="checkbox"/> CPAP does not seem to be effective           | <input type="checkbox"/> Lip Pressure causing tooth related problems      |
| <input type="checkbox"/> A latex allergy                              | <input type="checkbox"/> Claustrophobic associations                      |
| <input type="checkbox"/> An unconscious need to remove CPAP apparatus |   |

**Other Therapy Attempts**

What other therapy attempts have you had for breathing disorders?

(weight loss attempts, smoking cessation for at least one month, surgeries, etc.)

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Patient signature: \_\_\_\_\_

# THE EPWORTH SLEEPINESS SCALE

Check one in each row:	<u>0</u> No chance of dozing	<u>1</u> Slight chance of dozing	<u>2</u> Moderate chance of dozing	<u>3</u> High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. a theatre or 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 alunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Total Score: \_\_\_\_\_  
(Add columns 0-3)

# Berlin Questionnaire Sleep Evaluation

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Complete the following:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Circle: Male Female

## Category 1

Do you snore?

- Yes
- No
- Don't Know

If you snore, your snoring is?

- Slightly louder than breathing
- As loud as talking
- Louder than talking
- Very loud. Can be heard from other rooms

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

Has your snoring ever bothered other people?

- Yes
- No

Has anyone noticed that you quit breathing during your sleep?

- Nearly every night
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

## Category 2

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

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

- Nearly every day
- 3-4 times a week
- Don't know
- 1-2 times a month
- Never or nearly never

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

## Category 3

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

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

# Medical History

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

Please circle:

Antibiotics	Asprin	Barbiturates
Codeine	Iodine	Latex
Local Anesthetics	Metals	Penicillin
Sedatives	Sleeping Pills	Sulfa Drugs
Other _____	Other _____	Other _____

## List and Medications you are currently taking:

Please circle:

Antacids	Antibiotics	Anticoagulants
Antidepressants	Anti-inflammatory Drugs	Barbiturates
Blood thinners	Codeine	Cortisone
Diet Pills	Heart Medication	High Blood Pressure
Insulin	Muscle relaxants	Nerve Pills
Pain Medication	Sleeping Pills	Sulfa Drugs
Tranquilizers	Other _____	Other _____

## Medical History:

Please circle:

Anemia	Arteriosclerosis	Asthma
Autoimmune Disorders	Bleeding easily	Chronic Sinus problems
Chronic fatigue	Congestive heart failure	Current pregnancy
Diabetes	Difficulty concentrating	Dizziness
Emphysema	Epilepsy	Fibromyalgia
Frequent sore throat	GERD	Hay fever
Heart disorder	Heart murmur	Heart pounding or irregular beating
Heart pacemaker	Heart valve replacement	Heartburn
Hepatitis	High Blood Pressure	Immune system disorder
Head, face injury	Insomnia	Irregular heartbeat
Jaw joint surgery	Low blood pressure	Memory loss
Migraines	Morning dry mouth	Muscle spasms or cramps
Nighttime sweating	Osteoarthritis	Osteoporosis
Poor circulation	Prior orthodontic treatment	Recent, excessive weight gain
Rheumatic fever	Shortness of breath	Swollen, stiff, painful joints
Thyroid problems	Tonsillectomy	Wisdom teeth removed
Other: _____	Other: _____	Other: _____

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Family History

Have any members of your family (blood kin) had: Heart disease      Yes No  
High Blood Pressure      Yes No  
Diabetes      Yes No

Have any immediate family members been diagnosed or treated for a sleep disorder? Yes No

## Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

Never      Once a week      Several days a week      Daily      Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

Never      Once a week      Several days a week      Daily      Occasionally

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

Never      Once a week      Several days a week      Daily      Occasionally

Do you smoke?      Yes      No      Number of packs per day: \_\_\_\_\_

Do you use chewing tobacco?      Yes      No

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc, to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_