PREVENTIVE • RESTORATIVE • COSMETIC

Katherine Spellman, D.D.S. • Lauren Patrick, D.D.S.

4626 University Avenue • Des Moines, Iowa 50311

515•277•3766

www.universitydentalgrouppc.com

INSURANCE & FINANCIAL INFORMATION

Fee for the initial consultation and exam is due at the time of your appointment.

A panoramic x-ray is needed for your consultation and exam. If you do not already have a current panoramic x-ray on file with your regular dentist we can take one in our office. The charge for the panoramic x-ray is due at the time of your appointment.

Since there are a number of sleep appliances, Dr. Spellman and Dr. Patrick will decide at your appointment which appliance is best suited for your needs. Fees include all future appointments as well as any adjustments and most repairs that may be needed.

If at the initial appointment you decide to proceed with the appliance, impressions will be taken along with the measurements and bite registrations. The full fee of the sleep appliance will be due at this time.

We would also like to remind you that it is your responsibility to contact your insurance company regarding coverage for your sleep appliance. This may or may not be a covered benefit under your policy. If pre-authorization is needed we suggest you have this done before your appointment for consultation in our office.

We suggest you call your medical insurance regarding information on plan coverage for oral appliances for sleep apnea. The diagnostic code is **G47.33** and **E0486** is the code for the "oral appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting adjustment." Ask your medical insurer if a prior approval is needed.

For your convenience we accept MasterCard, Visa, Discover, as well as cash.

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MEDICAL SCREENING QUESTIONNAIRE

I want you to be aware of important new research in the medical/dental field that may affect you or your spouse. Please read this form, answer the questions below, and sign and date the form. This form will then become part of your permanent record and will ensure that all patients have been screened for this medical problem.

SNORING IS A SIGN THAT SOMETHING IS WRONG. It is a major problem, which affects over 40 million Americans, and is now considered by the National Institute of Health as the number one health problem in America.

Besides damaging close relationships, it is a sleep-breathing disorder, which narrows the airway and decreases the oxygen to the brain. As a result of snoring, high blood pressure can develop as well as heart and lung problems. This condition can be life threatening. Dental and medical treatment is available that can solve this problem.

Please circle your answer to the questions below.

1. Do you or your spouse snore? Yes No

   I do____Spouse____Both____

2. Is the snoring a problem? Yes No

3. Do you or your spouse have breathing problems which cause you to awaken at night? Yes No

4. Do you or your spouse suffer from daytime drowsiness or have to take naps during the day? Yes No

5. Do you or your spouse suffer from bad breath? Yes No

_______________________________ Signature

_______________ Date

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QUESTIONNAIRE FOR SNORING

Name_________________________ Age______ Sex______ Date________________

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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
-Sitting and reading	_____
-Watching TV	_____
-Sitting, inactive in public place (e.g. theater or meeting)	_____
-As a passenger in a car for an hour without a break	_____
-Lying down to rest in afternoon when circumstances permit	_____
-Sitting and talking to someone	_____
-Sitting quietly after lunch without alcohol	_____
-In car, while stopped for a few minutes in the traffic	_____
Total Score	_____

BEHAVIOR DURING SLEEP

Use the following scale to choose the most appropriate number for each situation:

0 = never during a usual night
1 = less than once a week
2 = once to about half the nights per week
3 = half the nights to almost always
4 = almost always or every night
? = don't know or haven't been told

During your usual sleep, you have noticed or have been told you do the following:

1. Snore loudly _____
2. Stop breathing _____
3. Choke, struggle for breath _____
4. Toss and turn frequently _____
5. Wake up with headache _____

Usual number hours of sleep per night _____
Number of times you rise to use toilet _____

Height _____ ft. _____ inches. Present body weight _____ lbs. Weight gained in last 12 mo. _____lbs.
Have you had an overnight sleep test? __________
What other doctors have you seen about your snoring, and what did they advise or do?
____
____
____
____

____
Signature

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