Snoring and Sleep Solutions
of Nevada

PATIENT INFORMATION

Mr./Ms./Mrs./Dr.

First Name: ________________________ Last Name: ________________________ MI: _____

Date of Birth: _______/_______/_______ Gender: [ ] Female [ ] Male

Home Phone: (____) ______________________ Cell Phone: (____) _____________________

Email Address: ____

Home Address: ____

City: ____________________________ State: _________ Zip Code: _____________________

Social Security Number (SSN): ________________________

Height: Feet ______ Inches ______ Weight: _____

Marital Status [ ] Single [ ] Married [ ] Life Partner [ ] Minor

Spouse or Parent/Guardian (*if minor*) Name: ____

Emergency Contact

Name: ____

Relationship: _______________________ Telephone: _________________________________

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AFFIDAVIT FOR INTOLERANCE TO CPAP

<u>Check the following that apply:</u>

______ **I have NOT** attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons:
______ Latex allergy
______ Claustrophobic associations
______ An unconscious need to remove the CPAP apparatus at night.
______ Other ____

______ **I HAVE** attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons:
______ Mask leaks
______ An inability to get the mask to fit properly
______ Discomfort or interrupted sleep caused by the presence of the device
______ Noise from the device disturbing my sleep or bed partner's sleep
______ CPAP restricted movements during sleep
______ CPAP does not seem to be effective
______ Pressure on the upper lip causes tooth related problems
______ Latex allergy
______ Claustrophobic associations
______ An unconscious need to remove the CPAP apparatus at night.
______ Other ____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT)

Print Name: ____________________________________

Signature: ______________________________________ Date: ________________________________

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GENERAL RELEASE OF LIABILITY & ASSUPTION OF RISK FOR OBSTRUCTIVE SLEEP APNEA

I, ______________________________ understand that due to the nature of sleep medicine that failure to comply with the treatment can result in severe physical and social issues including, but not limited to: coronary artery disease, stroke, congestive heart failure, atrial fibrillation, diabetes, increased motor vehicle accidents, hypertension, excessive sleepiness and increase mortality.

As Dr. Gil Suarez D.D.S and Thrive Dental Inc. cannot ensure success of any type of therapy and cannot guarantee that any patient will comply with the treatment for sleep apnea, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I might sustain as a result of my treatment for sleep apnea or any failure on my part to comply with treatment.

Therefore, I release Dr. Gil Suarez D.D.S and Thrive Dental Inc and his staff, from any and all liability associated with my treatment and I personally assume all risks associated with care, including, but not limited to: coronary artery disease, stroke, congestive heart failure, atrial fibrillation, diabetes, increased motor vehicle accidents, increased work place accidents, hypertension, excessive sleepiness, TMJ disease, periodontal disease and increased mortality.

I hereby agree to indemnify and hold Dr. Gil Suarez D.D.S and Thrive Dental Inc and his staff harmless for any issues or damages that might result from my sleep apnea treatment.

Name: ____________________________________ Date: ______________________________

Signature: ____

Witness Name: ______________________________ Date: ______________________________

Witness Signature: ____

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INFORMED CONSENT FOR THE TREATMENT OF SNORING AND/OR OBSTRUCTIVE SLEEP APNEA WITH ORAL APPLIANCE

Snoring and Obstructive Sleep Apnea are both breathing disorders that occur during sleep due to narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may often be no more problematic than the noise itself. However, consistent, loud, heavy snoring has been linked to medical disorders such as high blood pressure. Obstructive Sleep Apnea is a serious condition where the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, these can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure and occasionally heart attack and stroke. Because any sleep disordered breathing may potentially represent a health risk, all individuals are advised to consult with their physician or sleep specialist for accurate diagnosis of their condition before treatment can be started.

Oral appliances may be helpful in the treatment of snoring and Sleep Apnea. Those diagnosed with mild or moderate Sleep Apnea are better candidates for improvement with this therapy than those severely affected. Oral appliances are designed to assist breathing by keeping the tongue forward have substantially reduced sorning and Sleep Apnea for many people, there are no guarantee this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrow airway space in the throat and excess weight. Since each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or apnea for everyone.

Furthermore, some people may not be able to tolerate the appliance in their mouth. Also, many individuals will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and slight change in their "bite" diminish within an hour after appliance removal in the morning. A Morning Repositioner has been made for you and this must be used daily. On a rare occasion, a permanent "bite" change may occur requiring restorative therapy. It is advised that the oral appliance be checked at least twice a year to ensure proper fit and that the mouth examined at the time to assure a healthy condition. If any unusual symptoms occur, it is recommended that the appliance not be worn until an office visit is scheduled to evaluate the situation.

Individuals who have been diagnosed as having Sleep Apnea may notice that after sleeping with an oral appliance, they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high to prevent abnormal heart rhythms is to have a consultation with the sleep specialist and follow up sleep test while wearing the appliance. This is a must for apnea patients.

Please sign below indicating that you have read and understand this information concerning oral appliances for the treatment of Snoring and/or Sleep Apnea, and that you are willing to accept all risks known and unknown involved. You will receive a copy of this consent.

Print Name: ______________________________________

Signature: ______________________________________ Date: ______________________

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender **Male** ○ **Female** ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet	Inches	**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

Condition			Condition		
High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○

Co-morbidities +1 for each Yes response — Score

Condition			Condition		
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

Situation	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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 lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2** — Score

Frequency		**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code	Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total** Score

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PATIENT MEDICAL RECORD RELEASE FORM

This office coordinates treatment with your healthcare providers to help ensure maximum benefit to you. Please sign the record release form below so we can retrieve medical records related to sleep disordered breathing.

To: ____

From: Dr. Gil Suarez

We would like to request a copy of the following applicable:

All baseline PSG's, oximetry studies. And the patients most recent CPAP titration study

Any pertinent notes about patients past medical history

Patient Name: ________________________________ DOB: ______________________

We wish to obtain the records in this way:

_____ Please fax to the phone number listed below

_____ Please mail to us at the address listed below

_____ Pick up from office

Address: 7312 W. Cheyenne Ave. # 4 Las Vegas, NV 89129 **Fax:** 1-702-899-5501

I request and authorize the above named doctor or health care provider, or individual named in this request to obtain my medical records. A copy of this authorization or my signature thereon may be used with the same effectiveness as an original patient.

Signature: ________________________________ Date: ______________________