Gorman™
Health & Wellness

Patient Name: _____

Patient Sex: M F Birthday ____/____/____ Marital Status: ____

Address: _____ Apt #: _____

City & State: _____ Zip: _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Ext: _____

E-Mail Address: _____

Pharmacy Name: _____

Main Cross Streets: _____

Pharmacy Phone # _____

Social Security #: _____

Driver's License #: _____ State: _____

Employer: _____

Employer Address: _____

Emergency Contact: _____ Phone # _____

Relationship to Patient: _____

GUARANTOR INFORMATION – IF DIFFERENT FROM ABOVE

Guarantor Name: _____ Relationship to Pt: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone # _____

Employer: _____ Phone # _____

Employer Address: _____

Guarantor Social Security #: _____ Birthday: ____/____/____ Sex: ____

INSURANCE INFORMATION
PRIMARY

Insurance Co Name: _____

Employer of Policy Holder: _____

Name of Policy Holder: _____

Relationship to Patient: __

Insurance Claim Address: _____

Insurance Claim Phone # _____ Policy Holder Birthdate: ____/____/____ Sex: _____

Insurance ID # _____ Group # _____ Effective Date: _____

Secondary Insurance Co Name: _____

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insurance and any other health plan to the Vivos Breathing Wellness Center. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges and I authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signed: _____ Date: _____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of 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 that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your Vivos dentist, Vivos office staff and others outs de of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a durable medical equipment company that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protected health information be disclosed to obtain approval or authorization.

Healthcare Operations: We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may also call you by name in the waiting room when your doctor is ready to see you.

We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices. which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____
Signature of Patient or Personal Representative	**Name of Personal Representative**
_____	_____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ Spouse _____

_____ Child(ren)_____

_____ PrimaryPhysician_____

___ ___ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

Messages

Please call: _____ my home

_____ my work

_____ my cell: _____

_____ other: _____

If unable to reach me:

_____ You may leave a detailed message

_____ Please leave a message asking me to return your call

_____ Other _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

Adult New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Chief Complaint: _____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

Do you have a history of any of the following? (Check if "yes" to any of the following)

- ❑ Difficulty falling asleep at night
- ❑ Snoring
- ❑ Witnessed apneas
- ❑ Gasping/choking during sleep
- ❑ Drooling in sleep
- ❑ Dry mouth upon awakening
- ❑ Teeth grinding/clenching sleep talking
- ❑ Heart palpitations
- ❑ GERD/reflux/heartburn
- ❑ Excessive daytime sleepiness
- ❑ Tired/fatigue during the daytime
- ❑ Nasal allergies/hay fever/nasal congestion
- ❑ Asthma
- ❑ TMJ pain/jaw discomfort
- ❑ Bedwetting
- ❑ Erectile dysfunction
- ❑ Decreased libido
- ❑ Hypertension/high blood pressure
- ❑ Depressed mood/irritability
- ❑ Anxiety/stressed out
- ❑ Difficulty with concentration
- ❑ Memory problems
- ❑ Cold hands/feet
- ❑ Chest pain/chest discomfort
- ❑ Shortness of breath during the day
- ❑ Acting out dreams
- ❑ Morning headaches
- ❑ Difficulty staying asleep
- ❑ Excessive movements in sleep
- ❑ Nightmares/bad dreams
- ❑ Sleep walking

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____# of cups of tea per day

_____ # cans or glasses of soda per day _____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol: ❑ None ❑ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

---

Tobacco: ❑ None ❑ Yes _____ # of cigarette packs per day _____ # of years

---

Recreational Drugs (such as marijuana or cocaine): ❑ None ❑ Yes

If yes, which ones? _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Children: ❑ No ❑ Yes How many? _____

Pets: ❑ No ❑ Yes How many? _____ **What type of pet?** _____

Do you have any children or pets that sleep in your bedroom? ❑ No ❑ Yes _____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

❑ High blood pressure/hypertension	❑ Diabetes	❑ Chronic insomnia
❑ Heart disease	❑ Overweight/obesity	❑ Restless legs syndrome
❑ Stroke	❑ Snoring	❑ Multiple sclerosis
❑ Congestive heart failure	❑ Sleep apnea	❑ Sleep walking
❑ Depression	❑ Anxiety	

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION

LAMBERG QUESTIONNAIRE Version 14

Associating Snoring and Sleep Apnea with Health

1: TRADITIONAL SCREENING QUESTIONS

- ☐ Do you awaken unrefreshed or feel sleepy during the day due to restless sleep?
- ☐ Is your snoring loud enough to disturb others?
- ☐ Have you been aware of your snoring for a long time?
- ☐ Have you been told your breathing stops while asleep?
- ☐ Do you ever wake yourself from sleep feeling that you are choking?
- ☐ Have you ever had a sleep study?
- ☐ Have you tried CPAP? (Was the pressure > 10.5 cm? Y/N)
- ☐ Is your BMI > 27? Is your neck > 17" for a man, or > 15.5" for a woman?
- ☐ Do the edges of your tongue have a scalloped pattern?

2: CARDIOLOGY & VASCULAR MEDICINE

- ☐ Do you have high blood pressure or take medicine for hypertension?
- ☐ Have you been diagnosed with CAD, stroke, congestive heart failure, Afib, or other heart health issues?
- ☐ Do you have a pacemaker?
- ☐ Do you have elevated total cholesterol levels?

3: PULMONOLOGY

- ☐ Have you experienced difficulty breathing during the day?
- ☐ Do you have shortness of breath, even with mild exertion?
- ☐ Have you been diagnosed with COPD, asthma, or pulmonary hypertension?
- ☐ Is asthma worse at night?
- ☐ Do you have a chronic cough, either dry or productive?

4: GASTROENTEROLOGY

- ☐ Have you or your dentist noticed erosion on molars?
- ☐ Do you experience heartburn or acid reflux at night or when you awaken in the morning?
- ☐ Do you take heartburn medications, either prescription or OTC?

5: NEUROLOGY

- ☐ Do you experience numbness, tingling or pain in your feet or hands or head?
- ☐ Do you ever experience leg cramps at night?
- ☐ Do you ever experience muscle weakness or dizziness or difficulty with coordination?
- ☐ Have you ever been diagnosed with Alzheimer's or dementia?

6: ENDOCRINOLOGY

- ☐ Have you been diagnosed with diabetes or hypothyroidism?
- ☐ Have you unexpectedly gained or lost weight lately?
- ☐ Have you gone through menopause? Are you on HRT?
- ☐ Have you been diagnosed with low testosterone?
- ☐ Do you experience repetitive limb movements or jerks in sleep, urges to move legs, night sweats, or leg cramps?

7: OTOLARYNGOLOGY

- ☐ Do you have difficulty breathing through your nose?
- ☐ Do you experience a dry mouth upon awakening?
- ☐ Do you have allergies that make nasal breathing difficult?
- ☐ Is postnasal drip a frequent problem?

8: UROLOGY

- ☐ Do you experience erectile dysfunction?
- ☐ Do you experience decreased interest in sex or have you taken medications to enhance sexual performance?
- ☐ Do you ever leak urine involuntarily?
- ☐ Do you have to urinate several times at night, or have you been diagnosed with BPH?

9: DENTISTRY

- ☐ Do you grind your teeth while sleeping?
- ☐ Do your front teeth have a worn look?
- ☐ Have you had jaw muscles or joint pain, ringing in your ears, vertigo, or dizziness?
- ☐ Have you been diagnosed with periodontitis (gum disease)?
- ☐ Are your teeth crowded or crooked or jaws misaligned?

10: PSYCHOLOGY & PSYCHIATRY

- ☐ Are you irritable upon waking in the morning?
- ☐ Do you experience insomnia? (falling asleep or maintaining sleep)
- ☐ Do you experience depression, PTSD, memory, or concentration problems?
- ☐ Do you take medications for any of these conditions?

11: RHEUMATOLOGY

- ☐ Have you ever been diagnosed with gout?
- ☐ Have you ever been diagnosed with rheumatoid arthritis?

12: DERMATOLOGY

- ☐ Have you been diagnosed with atopic dermatitis (eczema) or psoriasis?

13: OPHTHALMOLOGY

- ☐ Have you been diagnosed with floppy eyelid syndrome, chronic eye irritation, dry eye syndrome, glaucoma, nonarteritic anterior ischemic optic neuropathy, papilledema, keratoconus, central serous chorioretinopathy, or macular edema?
- ☐ Are you taking antivascular endothelial growth factor medications for retinal disease?

14: CHRONIC PAIN

- ☐ Do you often wake up with headaches or have chronic headaches?
- ☐ Do you experience any chronic pain anywhere in your body?
- ☐ Do you take medications for pain on a daily basis?

15: HEPATOLOGY

- ☐ Have you ever been diagnosed with nonalcoholic fatty liver disease?

16: ONCOLOGY

- ☐ Have you ever been diagnosed with cancer?

17: OBSTETRICS (GESTATIONAL OSA)

- ☐ In prepregnancy: Are you 35 or older or is your BMI>25?
- ☐ Are you more fatigued, experience nasal congestion, or have frequent snoring?
- ☐ Has your BP or blood sugar increased significantly?

18: NEPHROLOGY

- ☐ Have you been diagnosed with kidney disease?

19: PEDIATRICS (EXCLUDE FROM SCORING)

- ☐ Do you know any children who are mouth breathers, have large tonsils, or who make any sleep breathing sounds?
- ☐ Do you know any children with bedwetting problems?
- ☐ Do these children have a crossbite or convex facial profile?

Risk level of having a sleep-related breathing disorder: 1 LOW 2-3 MODERATE 4+ HIGH

Name: _____ DOB: _____ Date: _____ Score: _____

Gorman™
Health & Wellness

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$

Gorman™
Health & Wellness

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, iin 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 effected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
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 (like a theater or a 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Analyze Your Score

Interpretation:	
From 0-7	It is unlikely that you are abnormally sleepy
From 8-9	You have an average amount of daytime sleepiness
From 10-15	You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention
From 16-20	You are excessively sleep and should consider seeking medical attention