SOUTHERNHEIGHTS
DENTAL GROUP

1575 20TH St NW Suite 102, Faribault, MN 55021

Dear ______________________________,

It is our pleasure to welcome you to *Southern Heights Dental Group*. We are dedicated to providing you with the highest quality of care to improve your health by helping you achieve a quiet, restful sleep. We want your visit to be comfortable and informative as possible.

We have scheduled an appointment for you on ______________________________ at ________________ in our Faribault office. At that time, the doctor will obtain a history of your symptoms and complete an examination of the head, neck and oral structures. We will also discuss your exam findings, diagnosis and treatment options. This appointment usually lasts about 2 hours.

Enclosed with this letter you will find the following:

- **Before your initial appointment information**
- **Patient checklist**

We participate in many medical insurance plans. If we are not a participating provider with your plan, we will ask you to pay for services at the time of your visit but we will file your insurance claims so you will receive reimbursement as soon as possible. Please call the customer service department of your insurance company to ask if we are a provider for your specific plan.

If you have questions or concerns, please give us a call. We look forward to working with you. Thank you!

Sincerely,

Southern Heights Dental Sleep Team
Jeffrey S. Forslund, DDS, DABDSM

Phone: 507-334-6433 Fax: 507-334-0044 E-Mail: sleep@southernheightsdental.com

Before Your Initial Appointment Information

Insurance

We recommend that you call your insurance company to determine if you have benefits for oral appliance therapy for treatment of obstructive sleep apnea. Your insurance company may ask for a CPT or HCPCS code to look up the treatment. The billing code for the appliance is E0486. Also ask your insurance company if a prior authorization is required before you can receive the oral appliance.

We are currently a provider for most Medica, Blue Cross Blue Shield, Preferred One, Health Partners, Medicare, and Aetna health plans. If you are covered by any other carrier, we will be out-of-network. Therefore, you will also want to ask your insurance carrier if you have out-of-network benefits and if so, what are those benefits. For out-of-network plans, we do require payment in full at the time of service. We then submit a claim to your insurance company on your behalf. Your insurance company will then reimburse you directly for any benefits for which you are entitled.

Referrals

If your insurance company requires a referral from your primary clinic in order to receive insurance benefits, please contact your primary physician to ensure the proper steps are being taken to put a referral into place before your appointment.

Check List

Information we would like to have prior to your appointment:

Sleep Study

Physicians written orders

Current medical insurance card (copy of the front and back)

Please bring the following items to your appointment:

Completed questionnaires (enclosed)

Any doctor's notes or test results, sleep studies or other information related to your sleep problem

Your oral appliance (i.e. splint/night guard), if you have one

Any panoramic x-rays from your dentist taken with in the last 2 years

Name and address of your physician, dentist and any other treating physician

List of current medications and the dosages

Patient Registration

Please fill in completely

Name: ______________________________ Gender: Male☐ Female☐ Date: ____________________

Address: ____

City: ______________________________ State: __________ Zip: ____________________

Home Phone: (____) ______________ Work Phone: (____) ______________ Cell Phone: (____) ______________

E-Mail address: ______________________________ Preferred form of contact: ____________________

Birth date: ______________________________ Social Security Number: ____________________

Employer: ____

How did you hear about our office? ____

Present dentist: ____

Address: ______________________________ Phone: (____) ____________________

City: ______________________________ State: ______________ Zip: ______________

Date of last visit: ____

Present physician: ____

Address: ______________________________ Phone: (____) ____________________

City: ______________________________ State: ______________ Zip: ______________

Are you now under the care of a physician? YES☐ NO☐

If yes, for what reason? ____

Health Insurance Information

Medical Insurance Company: ____

ID#: ______________________________ Group #: ______________________________

Subscriber's Name: ____________________ Subscriber's Social Security #: _____-____-______ DOB: ___/___/___

Records release: I hereby authorize Southern Heights Dental Group to release my information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patient Signature: ______________________________ Date: _____/_____/______ *(mm/dd/yyyy)*

SOUTHERNHEIGHTS
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Personal Medical and Social History
Sleep-Related

Name: ______________________________ **Date:** ______________________

Do you have or have had any pain in the following areas?
[Please circle any that apply] Jaw Ear Face Neck Teeth Headaches
Other: ____________________

Does your jaw make any of the following noises?
[Please circle any that apply] Clicking Popping Rubbing Grinding Crunching
Other: ____________________

Have you received treatment for any TMJ, head, or neck symptoms? Yes No
When was your last dental visit? ____________________
Have you ever been told that you have periodontal (gum) disease? Yes No
Do you have any existing problems with your teeth? Yes No
Describe: ____________________
Do you have any dental treatment planned? Yes No

Medical History

General			Seizures	Y	N
Change in Appetite	Y	N	Stroke	Y	N
Fever	Y	N	Tingling/Numbness	Y	N
General Weakness	Y	N	Tremor	Y	N
Marked Weight Change	Y	N	Alzheimer's Disease	Y	N
Night Sweats	Y	N	Multiple Sclerosis (MS)	Y	N
Polyuria (frequent urination)	Y	N	***Skin***		
Recent Trauma or Injury	Y	N	Acne	Y	N
Unusual Weakness	Y	N	Frequent Bleeding	Y	N
Chronic Fatigue Syndrome	Y	N	Bruising	Y	N
Hepatitis	Y	N	Eczema	Y	N
Tumors/Cancer	Y	N	Itch	Y	N
HIV/AIDS	Y	N	Lesions	Y	N
Allergies			Psoriasis	Y	N
Anaphylactic Reaction	Y	N	***Endocrine***		
Dairy	Y	N	Diabetes	Y	N
Dust	Y	N	Gout	Y	N
Excessive Sneezing	Y	N	Hormonal Changes	Y	N
Hay Fever	Y	N	Thyroid Problems	Y	N
Latex	Y	N	***Eyes, Ears, Nose and Throat***		
Penicillin	Y	N	Change in Hearing	Y	N
Sulfa Drugs	Y	N	Change in Smell	Y	N
Wheat	Y	N	Dysphagia (difficult swallowing)	Y	N
Neurological			Ear Pain	Y	N
Confusion	Y	N	Glaucoma	Y	N
Dizziness	Y	N	Hearing Loss	Y	N
Fainting	Y	N			

Memory Loss	Y	N
Muscle Weakness	Y	N
Ears, Eyes, Nose & Throat	Y	N
Sinus Problems	Y	N
Tinnitus (ringing in the ears)	Y	N
Visual Changes	Y	N

Cardiovascular

Coronary Artery Disease	Y	N
Chest Pain	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Tachycardia (rapid heart beat)	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Chest Pressure	Y	N
Colored Sputum	Y	N
Congestion	Y	N
Cough	Y	N
Dyspnea (shortness of breath)	Y	N
Emphysema	Y	N
Hemoptysis (coughing up blood)	Y	N
Hypoventilation Syndrome	Y	N
Orthopnea (shortness of breath while supine)	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Shortness of breath	Y	N
Tuberculosis	Y	N

Gastrointestinal

Black or Bloody Stool	Y	N
Constipation	Y	N
Diarrhea	Y	N
Gastroesophageal Reflux Disease	Y	N
Irritable Bowel Syndrome	Y	N
Stomach pain	Y	N
Ulcers	Y	N
Vomiting	Y	N

List any medications you are taking: Dosage

____

____

____

Hoarseness	Y	N
Nasal Discharge	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N

Genitourinary

Frequent Urination	Y	N
Hematuria (blood in urine)	Y	N
Incontinence	Y	N
Kidney Infections	Y	N
Kidney Stones	Y	N
Kidney Disease	Y	N
Prostate Problems	Y	N
Cervical/Uterine/Ovarian Cancer	Y	N
Breast Cancer	Y	N
Currently pregnant?	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Autism	Y	N
Depression	Y	N
Disorientation	Y	N
Excess Stress	Y	N
Hallucination	Y	N
Memory Problems	Y	N
Eating Disorders	Y	N
Chemical Dependency	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N
Limited range of motion	Y	N
Muscle Atrophy	Y	N
Muscle Pain	Y	N

Social History

Do you smoke? N Y_______packs a day

Do you consume alcoholic beverages?

________ Drinks per day/week/month

List any surgeries you have had:

____

____

____

List any Vitamins/Supplements you are taking:

____

____

____

I certify that the above information is correct to the best of my knowledge.

Patient signature:______________________________ **Date:**________________

SOUTHERNHEIGHTS
DENTAL GROUP

Initial Evaluation Questionnaire

Name: ______________________ DOB: ______________ Age: __________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Divorced and remarried ☐ Domestic partner

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other ______________

	Never	Rarely	Sometimes	Often
*Have you been told that you snore?	☐	☐	☐	☐
*Have you had choking or shortness of breath sensations at night?	☐	☐	☐	☐
*Have you woken up during sleep?	☐	☐	☐	☐
*Have you had morning fatigue or fogginess or woken up feeling unrefreshed?	☐	☐	☐	☐
*Have you woken up with a headache?	☐	☐	☐	☐
*Have you had chronic sleepiness, fatigue or weariness that you can't explain?	☐	☐	☐	☐
*Have you ever fallen asleep during the day, particularly when you are not busy?	☐	☐	☐	☐
*Have you fallen asleep reading or watching tv?	☐	☐	☐	☐
*Have you fallen asleep during the day against your will?	☐	☐	☐	☐
*Have you had to pull off the road while driving due to sleepiness?	☐	☐	☐	☐
*Have you been more irritable and short tempered?	☐	☐	☐	☐
*Have you felt your memory and or intellect is impaired?	☐	☐	☐	☐
*Have you been told you stop breathing while asleep?	☐	☐	☐	☐

Signature: ______________________________ Date: ______________

SOUTHERNHEIGHTS
DENTAL GROUP

Questionnaire for Sleep Apnea and/or Snoring

Name: ______________________ DOB: ______________

How long have you been aware of your snoring? ______________

Has it caused problems for relatives or friends? ______________

Have you been told your breathing stops while asleep? ______________

Have you been told you move around a lot while asleep? ______________

About how many times per night do you wake up? ______________

Do you have any difficulty falling asleep at night? ______________

How many hours of sleep per night do you get? ______________

Do you most often wake up feeling refreshed? ______________

Do you often wake up with a headache? ______________

Will a small amount of alcohol give you a hangover? ______________

Do you feel sleepy during the day? ☐ Frequently ☐ Occasionally ☐ Seldom ☐ Never

What other doctors have you seen about your snoring or sleep apnea? ______________

Have you had a sleep lab study? _____ YES _____ NO

Do you have difficulty breathing through your nose? _____ YES _____ NO

Have you gained weight recently? _____ YES _____ NO If yes, about how much? ___________

Present body weight: _________ Height: _________ft. _________inches

What professional advice or treatment have you received about your snoring or sleep apnea?

____

____

____

Signature: ______________________ Date: ______________

The Epworth Sleepiness Scale

Name: ______________________________ Date: ______________________

Your Age: ____________________ Your Sex: ________ Male ________ Female

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 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 (0-3)
Sitting and reading ______________________	_____
Watching TV ______________________	_____
Sitting, inactive in a public place (e.g. theater 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 lunch without alcohol ______________	_____
In a car, while stopped for a few minutes in the traffic __________	_____
Total: ______________________	_____

Rating Scale

0-10	Normal range in healthy adults
11-14	Mild sleepiness
15-17	Moderate sleepiness
18 or higher	Severe sleepiness

Bed Partner/Witness Screening Questionaire: Obstructive Sleep Apnea

Patient's Name: ______________________________ **Date:** ______________

Person completing the form: ____

Please answer the following questions as they pertain to your bed partner in the past month

Question			
1. While sleeping, does your partner?			
Snore more than half the time?	Y	N	Don't Know
Always snore?	Y	N	Don't Know
Snore loudly?	Y	N	Don't Know
Have "heavy" or loud breathing?	Y	N	Don't Know
Have trouble breathing, or struggle to breath?	Y	N	Don't Know
2. Have you ever seen your partner stop breathing during the night?	Y	N	Don't Know
3. Does your bed partner ever have snorting or choking episodes during the night?	Y	N	Don't Know
4. Does your partner:			
Tend to breathe through the mouth?	Y	N	Don't Know
Have a dry mouth when waking up in the morning?	Y	N	Don't Know
Occasionally wet the bed?	Y	N	Don't Know
5. Have you ever experienced your partner:			
Grinding their teeth during the night?	Y	N	Don't Know
Have twitching or kicking of their legs or arms?	Y	N	Don't Know
6. Does your partner:			
Wake up feeling unrefreshed in the morning?	Y	N	Don't Know
Have a problem with sleepiness during the day?	Y	N	Don't Know
7. Has a friend, co-worker or supervisor commented that your partner appears sleepy during the day?	Y	N	Don't Know
8. Is it hard to wake your partner up in the morning?	Y	N	Don't Know
9. Does your partner wake up with headaches in the morning?	Y	N	Don't Know

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of their medical services, we have established our financial policy. Some of these are required by law. It is our goal to remain sensitive to our patients' needs while providing quality care and we encourage you to contact our office if at any time a problem should arise regarding your account.

1.) All co-pays and co-insurances required by your insurance company must be paid at the time of service. We can accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit cards as a form of payment.

2.) It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier. If your insurance requires a referral for full benefits to be paid, it is your responsibility to verify that the referral is in place prior to your visit with us.

3.) Since Southern Heights Dental Group offers you comprehensive care for your treatment, you may be charged for the following services if applicable:
**Office visit, Consultation, Treatment or Follow-up.

4.) Our facility will file both primary and secondary insurance claims for dental services rendered. Claims for a third insurance will not be filed unless required by our contract with the insurance carrier. We cannot file claims correctly without accurate information from you. Proof of your insurance must be presented at each visit.

5.) If you do not have insurance, payment is expected to be paid in full at the time of service unless financial arrangements have been made in advance with our billing department.

6.) You will receive a statement from our office within 30 days of your insurance company's response. If you are dissatisfied with their payment, please contact your insurance carrier. The patient portion of your balance is due upon receipt of this statement.

7.) Cancelled appointments without a 24-hour notice are subject to a fee. This fee will not be billed to your insurance company and you will be responsible for the payment.

8.) All accounts 90 days or more past due will be turned over to a collections agency and Southern Heights Dental Group may cease providing services to you.

9.) In the unlikely event your payment is returned to us unpaid, we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed what is permitted by state law.

10.) I assign payment directly to Southern Heights Dental Group under the conditions of my health care plan for basic and major medical benefits payable to me. The rates will not exceed our regular charges. I understand that the billing of my insurance is a service and is not a guarantee of payment. If my insurance carrier requires a prior authorization for services, I realize that it is my responsibility to get the necessary approval. I understand that I am financially responsible for the full amount of the bill if the insurance does not pay within 30 days of billing or if the charges are not covered by this agreement.

11.) I authorized Southern Heights Dental Group to bill and receive payment for products and services they have provided me. If my insurance reimburses me directly instead of Southern Heights Dental Group, I will submit payment to Southern Heights Dental Group for the same amount I received.

12.) I hereby authorize Southern Heights Dental Group to provide products and services to me with respect to my condition as directed by my physician.

______________________________ ____________ ____________

Patients Signature ***Date*** ***Date of Birth***

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

1.) I authorize Southern Heights Dental Group to release any medical information about my treatment, including copies of my records, needed payment of those claims, quality assurance review, or the provision of care after discharge. I reserve the right to revoke in writing this consent except when actions have been taken based on it.
2.) I authorize Southern Heights Dental Group, a privately-owned company, to obtain my medical information and disclose the information to my insurance company.

______________________________ ____________ ____________

Patients Signature ***Date*** ***Date of Birth***

Billing and Insurance Policy

Southern Heights Dental Group would like to thank you for choosing us as your provider. We are committed to you and your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require to read and sign prior to any treatment.

In-network Providers

We are providers for most Medica, Blue Cross Blue Shield, Preferred One, Health Partners, Medicare, and Aetna health plans. We will expect payment of any applicable co-payments at the time of service.

Out-of-network Providers

If you have coverage through any other insurance carriers, payment in full will be due at the time of service. We will send all claims to your insurance company and they will send all payments or correspondence to you directly. If needed, we will be happy to assist you in getting reimbursement.

Referrals

Insurance plans require a referral from your Primary Care Clinic or Physician before you can receive coverage. To obtain a referral you will need to contact your Primary Care Clinic or Physician to make sure that all appropriate referrals are in place prior to starting treatment.

Insurance

We strongly recommend that you contact your insurance company prior to treatment to confirm the amount or percent of coverage for your care in this office. Your insurance company may ask you for a CPT or HCPCS code for your treatment. The billing code for an oral apnea appliance is E0486. It is important that you confirm your financial responsibility before we begin treatment to avoid any misunderstandings.

I have read, understand and agree to the following policies as stated above.

Signature: ______________________________ **Date:** ____________________