SLEEP BETTER VIRGINIA • Erika C. Mason, DDS, D-ABDSM, D-ACSDD

PATIENT INFORMATION

Name: First _____ Last _____ MI _____ Preferred: _____

Address: _____ City: _____ State: ____ Zip: _____

_____ Email: _____

Phone: Home _____ Work _____ Cell _____ (Circle Preferred)

DOB: _____ SSN: _____ Sex: M F Unknown (Circle One)

Marital Status: Single Married Separated Divorced Widowed Spouse's Name _____

Patient Employer: _____ Spouse Employer: _____

Primary Care Physician: _____ Sleep Physician: _____ Dentist: _____

MEDICAL INSURANCE INFORMATION

Financially Responsible Person: _____ Relation to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

DOB: _____ SSN: _____ Phone: _____

Primary Insurance Co. _____ ID _____

Group No. _____ Plan through Employer? _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

Secondary Insurance Co. _____ ID _____

Group No. _____ Plan through Employer? _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

Tertiary Insurance Co. _____ ID _____

Group No. _____ Plan through Employer? _____

Subscriber's Name: _____ DOB: _____ Relation to Patient: _____

EMERGENCY INFORMATION

Person to Contact: _____ Relation: _____

Contact Phone Number(s): _____

How did you hear about us? Friend Web Radio Yellow Pages Doctor Direct Mail Boomer Magazine

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MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____/_____/_____

(First, MI, Last)

ALLERGENS

- ☐ No Known Allergies
- ☐ Acrylic
- ☐ Antibiotics (What type? - Ex. Penicillin)

  _____
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals (Ex. Nickel)
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleep Aids
- ☐ Sulfa Drugs
- ☐ Other: _____

  _____

  _____

  _____

CURRENT MEDICATIONS

Medication	Dosage/Frequency	Year Started/Reason?

(Please attach separate sheet with additional medications if needed.)

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DETAILED MEDICAL HISTORY

Medical Condition	Age/Year Diagnosed	Medical Condition	Age/Year Diagnosed
☐ Acid Reflux/GERD		☐ Glaucoma	
☐ AFib		☐ Gout	
☐ Anemia (Low Iron)		☐ Heart Attack	
☐ Anxiety		☐ Heart Disease/Failure	
☐ Atherosclerosis (Artery Disease)		☐ Heart Murmur	
☐ Arthritis (Ex Rheumatoid, Osteo)		☐ Heart Pacemaker	
☐ Asthma		☐ Heart Valve Replacement	
☐ Autoimmune Disorder		☐ Hepatitis	
☐ Bleed/Bruise Easily		☐ Hypoglycemia (Low Sugar)	
☐ Blood Pressure - HIGH		☐ Kidney Problems	
☐ Blood Pressure - LOW		☐ Liver Disease	
☐ Cancer		☐ Meniere's Disease	
☐ Cataracts		☐ Migraines/Headaches	
☐ Chemotherapy		☐ Mitral Valve Prolapse	
☐ Chronic Pain		☐ Mood Disorder	
☐ COPD		☐ Multiple Sclerosis	
☐ Current Pregnancy		☐ Muscular Dystrophy	
☐ Depression		☐ Neuralgia	
☐ Diabetes		☐ Orthodontics (Braces)	
☐ Difficulty Sleeping		☐ Osteoporosis	
☐ Dizziness		☐ Parkinson's Disease	
☐ Emphysema		☐ Prostate Problems	
☐ Epilepsy		☐ Psychiatric Care	
☐ Fibromyalgia		☐ PTSD	

DETAILED MEDICAL HISTORY

Medical Condition	Age/Year Diagnosed
☐ Radiation Treatment	_____
☐ Restless Legs Syndrome	_____
☐ Rheumatic Fever	_____
☐ Sinus Problems/Allergies	_____
☐ Sleep Apnea	_____
☐ Stroke	_____
☐ Thyroid Disorder	_____
☐ Tuberculosis	_____
☐ Tubes in ears	_____
☐ Tumors	_____
☐ Urinary Disorders	_____

Other medical conditions/notes: _____

CONFIDENTIAL MEDICAL HISTORY

☐ HIV/AIDS Age/Year Diagnosed: _____

☐ Recreational Drug Use Type/Frequency: _____

SURGICAL OPERATIONS

	Age/Year Completed		Age/Year Completed
☐ Appendectomy	_____	☐ Hernia Repair	_____
☐ Back Surgery	_____	☐ Heart Surgery	_____
☐ Cosmetic Surgery	_____	☐ Lung Surgery	_____
☐ Dental Surgery:		☐ Nasal/Sinus Surgery	_____
☐ Extractions	_____	☐ Organ Transplant	_____
☐ Periodontal (Gum)	_____	☐ Thyroid Surgery	_____
☐ Implants	_____	☐ Tonsillectomy/Adenoidectomy	_____
☐ Ear Surgery (Ex. Tubes)	_____	☐ Tumor Removal	_____
☐ Eye Surgery (Ex. Cataract, Lasik)	_____	☐ Uvulectomy	_____
☐ Gallbladder Surgery	_____	☐ Other:	_____

_____

FAMILY HISTORY

Has any member of your family (sibling, parent, grandparent) had:

☐ Cancer	☐ Heart Attack	☐ Sleep Apnea
☐ Diabetes	☐ High Blood Pressure	☐ Snoring
☐ Heart Disease	☐ Obesity	☐ Thyroid Disorder

SOCIAL HISTORY

Patient Occupation: _____ Employer: _____

Tobacco Use: ☐ Never Used Tobacco ☐ Use Tobacco Currently ☐ Quit - What Year? _____

If current tobacco user: ☐ Cigarettes ☐ eCigs ☐ Cigars ☐ Pipe ☐ Hookah ☐ Smokeless Tobacco Quantity? _____

Alcohol Use: ☐ Never Drink ☐ Social Drinker - How Often? _____ ☐ Drink Regularly - How Often? _____

If you drink, what do you drink mostly? ☐ Wine ☐ Beer ☐ Liquor - How Many Per Day, on Average? _____

Caffeine Intake: ☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink - How Often/How Many Ounces? _____

Physical Activity: ☐ No Exercise ☐ Regular Exercise -- Walking Running Strength Yoga Other _____

I certify that the medical history information I provided is complete and accurate to the best of my ability.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____/_____/_____
(First, MI, Last)

HT: _____ FT _____ IN WT: _____ LBS Neck Measurement (if known): _____ IN

PHYSICIAN/SPECIALIST LIST

Primary Care Physician: _____ Phone: _____

Sleep Physician: _____ Phone: _____

Other Specialist: _____ Phone: _____

Other Specialist: _____ Phone: _____

Other Specialist: _____ Phone: _____

Dentist: _____ Phone: _____

Other: _____ Phone: _____

Lastly, What are the Chief Complaints for which you are seeking treatment?

□ CPAP Intolerance (Circle any that apply): Claustrophobia | Mask Leaks | Noisy/Disrupts Sleep
Restricts Movement | Ineffective | Mask/Headgear Discomfort | Latex Allergy | Other: _____

_____

□ Chronic Fatigue
□ Difficulty Concentrating/Forgetfulness
□ Excessive Daytime Sleepiness
□ Insomnia
□ Nighttime Choking/Gasping
□ Significant Other Urged Me to Seek Treatment
□ Snoring
□ Sleepy Driving/CDL License
□ Witnessed Cessation (Stopping) of Breathing
□ Failed Attempts at Treatment (ex. Weight Loss, Surgery): _____

Sleep Better Virginia

Erika C. Mason, D.D.S.

Diplomate, American Board of Dental Sleep Medicine

Diplomate, Academy of Clinical Sleep Disorders Disciplines

11061 Hull Street Road Midlothian, VA 23112 (804) 745-0624 phone (804) 675-0938 fax

General Consent for Treatment, Assignment of Benefits, & Patient Responsibility for Payment

I, the undersigned (patient or legally authorized representative), do hereby (Initial):

_____ **Give Consent for Treatment**

Consent for routine medical/dental treatment and/or evaluation, including, but not limited to: oral examination and radiographic (x-ray) examinations. I understand that separate consents may be requested for special procedures.

_____ **Give Consent for Photographs** _____ **Decline All Photographs** _____ **Educational Photographs ONLY**

Consent to give Dr. Erika Mason (Sleep Better Virginia) the absolute and irrevocable right and permission for any photographs taken of me to be used and republished for both educational and commercial (including, but not limited to: illustration, promotion, advertising, trade) use globally until December 31, 2099.

Assignment of Benefits

Assign all benefits under my insurance or health benefit plan(s) for payment for medical or dental services rendered by Dr. Erika Mason (Sleep Better Virginia). I further agree to remit payment within fourteen (14) days of any benefits paid directly to me for the payment of medical or dental services.

Patient Responsibility for Payment

I accept financial responsibility for any amount not paid by insurance or other health benefit plans. I agree to pay my co-payment amount (if known) at each visit, as well as my deductible if it has not been satisfied. I understand that legally my deductible amount cannot be written off. In the event that payments are not received by me after billing cycles, I understand that a 1.5% late charge (18% APR) may be assessed to my account. I also understand that if this contract is referred to an attorney or collection agency for resolution of my account balance, I am subject to pay any attorney or collection fees in the amount of 25% of the total indebtedness and any court costs incurred by Dr. Erika Mason.

Missed Appointment Fees

I understand that Dr. Erika Mason (Sleep Better Virginia) may, at their discretion, charge a missed appointment fee in the amount of $75 for appointments missed by me or for cancellations of less than 48 hours. I also understand that for repeat offenses I may be asked to place a credit card on file that will be charged the missed appointment fee if I do not show up to the appointment.

Patient/Legal Rep Signature: _____ Date: _____

Witness (Staff) Signature: _____ Date: _____

For Legally Authorized Representatives ONLY

Relationship to Patient: _____ Reason: □ Minor Patient □ Other/POA (Copy of legal documentation requested)

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Acknowledgement of Receipt of Notice of Privacy Practices

(You May Refuse to Sign This Form)

I am signing in acknowledgement that I have had the opportunity to receive and review a copy of this office's (Sleep Better Virginia/Erika C. Mason, D.D.S.) Notice of Privacy Practices.

Printed Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barrier prohibited obtaining the acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other: _____

_____

_____

Staff Signature: _____ Date: _____

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Disclosure to Family Members and/or Friends

I understand that with my permission, disclosures related to my health may be made to my family and/or friends, if I so choose. These disclosures will be relevant ONLY to my current treatment as a patient at Sleep Better Virginia. I permit Sleep Better Virginia to disclose my routine health care information to the following contact(s):

Contact Name	**Phone Number**	**Relation to Patient**

If I should become incapacitated or an emergency circumstance arise while under the care of Dr. Mason and Sleep Better Virginia, I authorize that any health care status be disclosed for health care services (eg. Rescue Squad) and that the following emergency contact(s) be called:

Contact Name	**Phone Number**	**Relation to Patient**

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Request for Release of Medical Records

To: _____

Physician or Hospital

_____

Address City State Zip

I am requesting that my medical records be released to Dr. Erika Mason:

Sleep Better Virginia - Erika C. Mason, D.D.S.

11061 Hull Street Road

Midlothian, Virginia 23112

804-745-0624 phone

804-675-0938 fax

_____

Patient Name Date of Birth SSN

_____

Address City State Zip

Patient Signature: _____

Records Needed: _____

_____

_____

Sleep Better Virginia

Erika C. Mason, D.D.S.

Diplomate, American Board of Dental Sleep Medicine

Diplomate, Academy of Clinical Sleep Disorders Disciplines

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Member Authorization for a Designated Representative to Appeal Adverse Determination

To: _____

_____

_____

Date: _____

Member Name: _____ Date of Birth: _____

Member ID: _____

I hereby authorize the billing staff of **Dr. Erika Mason (Sleep Better Virginia)** to appeal my insurance carrier's determination concerning any denials of claims or incorrect payment of claims (including delayed payment of claims) on my behalf, as my Designated Representative. As part of the appeal, I hereby authorize my insurance carrier in all aspects of the appeal process to communicate with my Designated Representative. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including, but not limited to treatment for venereal disease, alcoholism and/or drug abuse abortion, mental disorder(s), and HIV status relating to my examination, treatment, and hospital confinement in connection with the determination being appealed.

I understand this information is privileged and confidential, and will only be released as specified in this Authorization or as required or permitted by law. This Authorization is valid for any adverse determination unless I choose to rescind in writing.

Patient/Legal Rep Signature: _____ Date: _____

Witness (Staff) Signature: _____ Date: _____

For Legally Authorized Representatives ONLY

Relationship to Patient: _____ Reason: □ Minor Patient □ Other/POA (Copy of legal documentation requested)

EPWORTH SLEEPINESS SCALE

Patient: _____ DOB: _____

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would never doze or sleep

1 = slight chance of dozing or sleeping

2 = moderate chance of dozing or sleeping

3 = high chance of dozing or sleeping

SITUATION	**Chance of Dozing or Sleeping**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic	_____

Total Score _____

Patient's Signature: _____ **Date:** _____

AFFIDAVIT FOR INTOLERANCE TO CPAP DEVICE

Patient: _____ DOB:_____

I have attempted to use a CPAP device to manage my sleep-related breathing disorder and find it intolerable to use on a regular basis for the following reason(s):

◊ Mask Leaks
◊ Mask and/or device uncomfortable
◊ Unable to sleep comfortably
◊ Noise from the device disturbs me and/or my bed partner's sleep
◊ Restricts movement during sleep
◊ Does not seem to be effective
◊ Straps/headgear cause discomfort
◊ Pressure on upper lip causes tooth-related problems
◊ Latex allergy
◊ Claustrophobia
◊ Other _____

I have not attempted to use a CPAP device and would prefer to use an oral appliance for the following reason(s):

◊ I'm worried that the mask, straps/headgear will cause discomfort
◊ I'm worried that the noise from the device will disturb me and/or my bed partner's sleep
◊ I'm worried that the device will restrict movement during sleep
◊ I have a latex allergy
◊ I suffer from claustrophobia
◊ I travel frequently and am worried that a CPAP device will be cumbersome to transport
◊ Other:_____

Because of my inability to use a CPAP device, I wish to have an alternative method of treatment. I would like to try an oral appliance in an attempt to control my snoring and obstructive sleep apnea

Patient's Signature _____ Date:_____