# Sleep Patients Packet

Name: ______________________________ Phone: ______________________________

**Minnesota Craniofacial Center - Midway**
1690 University Avenue West, Suite 390
University Park Medical Center
St. Paul, MN 55104

**651.642.1013**

***Welcome to our practice!*** ***We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to provide the highest quality care and service to our patients. We take great pride in each staff member's training and capabilities. So that we might all enjoy a smooth working relationship, we ask you to take a few minutes to read over our practice policies, below:***

**APPOINTMENTS:** We strive to keep our patient's "waiting time" to a minimum, as we recognize that your time is valuable. Therefore, we are able to see our patients on an appointment basis only (with the exception of emergencies). We consider an appointment made to be an agreement and commitment between our office and our patients, and we rely on our fine patients to abide by their agreement. We reserve the right to reschedule your appointment if you arrive more than 15 minutes past your scheduled appointed time.

**EMERGENCIES:** As emergencies do arise, we ask your patience and understanding in the event of our having to place an emergency patient in front of your appointment slot. We will try to inform you of any changes necessary ahead of time, if at all possible.

**FINANCIAL ARRANGEMENTS:** During your first visit, our accounts manager will meet with you. Please direct all inquiries about your account to her rather than to the treatment staff. Our accounts manager will be most happy to discuss how our office handles your insurance benefits, if applicable; how your co-payments (if any) are to be taken care of; how any secondary insurance is handled; and how our office financial policy is administered. She will help you arrange the most suitable method of payment for your care. For your convenience, we accept Visa and Master Card.

**INSURANCE:** As a courtesy to you, we will be happy to submit all insurance claims for services rendered in our office. However, it is up to you to know if your insurance plan requires a referral or a prior authorization, whether insurance deductibles have been met, if there are plan exclusions for TMJ treatment or dental sleep appliances, what percent of coverage you have, whether you are required to make co-payments and what the co-payment will be, and what your plan maximum coverage is per year. Please see the enclosed form to use when calling your insurance company.

**OUR COMMITMENT TO YOU:** We appreciate having you as a patient in our practice. We will do everything to deliver the highest quality care in a safe, comfortable and caring environment. Please do not hesitate to ask any questions you might have about our services and office policies. In addition, if you are satisfied with our services, please feel free to tell a friend. We welcome new patients and appreciate referrals of your family and friends.

*Very sincerely, Dr. Roy Hakala and Staff*

**YOUR COMMITMENT TO US: I understand that I am ultimately responsible for my account in this office, regardless of what insurance benefits or other third-party compensation may or may not be applied to my account. I authorize payment of any medical benefits directly to MCCM.**

I also consent to the release and retrieval of my personal health information by MCCM to and from my medical and/or any automobile or other insurance companies, and all third parties involved in my care.

I agree to a charge of $50.00 per scheduled hour if I fail or cancel a scheduled appointment **without giving MCCM a 24-hour notice.**

________________________________________ ____________________

**Patient signature** **Date**

## THE EPWORTH SLEEPINESS SCALE

Name: ____________________________________________________
Today's Date: ______________________
Age: _____________
Gender: _____________

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 decide how they are likely to affect you. Use the following scale to choose the most appropriate number for each situation, and write the number in the blank:

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 a public place such as 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 | ___________ |

**Thank you for you cooperation!**

## Patient Medical & Insurance Information

***Please fill out all that apply completely using black or blue pen.***

Name: ______________________________________
Date of Birth: ________________________________
Address: ____________________________________
City: _______________________________________
State: _____________ Zip: ____________________
Home #: ____________________________________
Work #: _____________________________________
Cell #: ______________________________________
Employer: ___________________________________
**If Minor, Name of Responsible Party:**
___________________________________________
*******************************************
Primary Health Insurance: ____________________
Billing Address: _____________________________
City: _______________________________________
State: ____________ Zip: _____________________
Phone #: ____________________________________
Subscriber __________________________________
Subscriber DOB: _____________________________
Policy/Group #: ______________________________
ID # _______________________________________
*******************************************
Secondary Health Insurance: __________________
Billing Address: _____________________________
City: _______________________________________
State: _____________ Zip: ____________________
Phone #: ____________________________________
Subscriber: __________________________________
Subscriber DOB: _____________________________
Policy/Group #: ______________________________
ID #: _______________________________________
*******************************************
Auto Insurance: ______________________________
Billing Address: _____________________________
City: _______________________________________
State: _____________ Zip: ____________________
DOI: ____________ Claim #: __________________
Adjuster Name: ______________________________
Phone #: ____________________________________
Policy Holder: _______________________________
*******************************************
Other Insurance Info (Workers Comp/Personal Injury) Company Name: ______________________
Billing Address: _____________________________
City: _____________ State: _______ Zip: ________
Subscriber: ___________________ DOB: _________
Policy#: ______________ID #: _________________

**Emergency Contact:** _________________________
**Phone #:** _____________________________________
*******************************************
Physician: ____________________________________
Clinic Name: __________________________________
Address: ______________________________________
City: _________________________________________
State: _________________ Zip: _________________
Phone #: ______________________________________
*******************************************
Dentist: _______________________________________
Clinic Name: __________________________________
Address: ______________________________________
City: _________________________________________
State: _________________ Zip: _________________
Phone #: ______________________________________
*******************************************
Chiropractor: __________________________________
Clinic Name: __________________________________
Address: ______________________________________
City: _________________________________________
State: _________________ Zip: _________________
Phone #: ______________________________________
*******************************************
Neurologist: ___________________________________
Clinic Name: __________________________________
Address: ______________________________________
City: _________________________________________
State: _________________ Zip: _________________
Phone #: ______________________________________
*******************************************
Other Care Provider: ____________________________
Clinic Name: __________________________________
Address: ______________________________________
City: _________________________________________
State: _________________ Zip: _________________
Phone #: ______________________________________
*******************************************
Attorney: ______________________________________
Contact: _______________________________________
Address: ______________________________________
City: _________________________________________
State: _________________ Zip: _________________
Phone #: ______________________________________
*****************************************

**Office Use Only**

IE Sent: _______________________________________

MN Craniofacial Center Midway, PA

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PLEASE FILL OUT COMPLETELY**

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

**SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Roy V. Hakala, DDS

Telephone: 651-642-1013 Fax: 651-642-0947

E-mail: info@mncranio.com or drhakala@mncranio.com

Address: 1690 University Avenue West Suite 390 Saint Paul, MN 55104

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SECTION C: PLEASE PRINT YOUR NAME ON THE LINE, SIGN, AND DATE BELOW**

I, ________________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature: ____________ Date: ______________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**
**Include completed Consent in the patient's chart.**

## Sleep Disorder Medical History

Welcome to our office! Today you will be given an examination regarding your suitability for an oral snoring and/or sleep apnea appliance. Records such as x-rays and diagnostic models may be necessary to form a complete diagnosis. Please answer these questions as completely as possible. Some of the material is repetitive, but it is necessary both to help us be thorough and to help you obtain any insurance benefits that may apply. Thank you for your help.

Name: ______________________________________________ Age: ________ Today's Date: ________

Gender: ___ Male ___ Female Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Please describe your chief complaints: ______________________________________________________

______________________________________________________________________________

Occupation: ______________________ Typical job duties: ____________________________________

Work schedule: ________________________________________________________________________

**MEDICAL HISTORY: Do you have or have you ever had any of the following conditions?**

| Now | Past | No | | Now | Past | No | |
|---|---|---|---|---|---|---|---|
| | | | Allergies or Asthma | | | | AIDS |
| | | | Anemia | | | | Arthritis |
| | | | Eating Disorder | | | | Tuberculosis |
| | | | Bleeding Problems | | | | Tonsillitis |
| | | | High Blood Pressure | | | | Low Blood Pressure |
| | | | Bone Disorder | | | | Cancer |
| | | | Chronic Pain | | | | Diabetes |
| | | | Dizziness | | | | Alcoholism or Drug Addiction |
| | | | Ear Pain | | | | Ear Congestion |
| | | | Facial Pain | | | | Stomach Problems |
| | | | Intestinal Problems | | | | Headaches |
| | | | Heart Disease | | | | Ringing Ears |
| | | | Hepatitis | | | | Kidney Disease |
| | | | Neurologic Problems | | | | Psychiatric Problems |
| | | | Sleep Disturbance | | | | TMJ Pain |
| | | | TMJ Clicking | | | | TMJ Grating |

Please describe any items marked above: _____________________________________________________

______________________________________________________________________________

Do you smoke? ________ If so, how many packs per day? ________________________________________

Do you use alcohol? _____________ If so, how may drinks per week? ______________________________

Do you use any recreational drugs? Describe: ________________________________________________

Are you pregnant? _______ If so, expected date of delivery: _____________________________________

**FAMILY HISTORY** Father: Age, if living: _____ His general health: ___________________________
Or, age at death: _________ Cause of death: _______________________________
Mother: Age, if living: _____ Her general health: ____________________________
Or, age at death: _________ Cause of death: _______________________________

Are there any inherited health conditions or genetic disorders in your family? _______________________

Please specify: ______________________________________________________________________

Are you currently taking any drugs or medications? Please list below.

| MEDICATION | DOSE | CONDITION |
| --- | --- | --- |
| ______________________________________________ | ____________________ | FOR__________________ |
| ______________________________________________ | ____________________ | FOR__________________ |
| ______________________________________________ | ____________________ | FOR__________________ |
| ______________________________________________ | ____________________ | FOR__________________ |

Please list any vitamins or minerals you take. Specify amount: ___________________________________
___________________________________________________________________________________

Are you allergic to any medications, foods, or latex? ___________________________________________

Date of last physical exam: ____________Conditions treated:
____________________________________

Please list your most serious illnesses and injuries: _____________________________________________
___________________________________________________________________________________

Please list any surgery or hospitalizations you have had: ________________________________________
___________________________________________________________________________________

Has any dental treatment been recommended to you, that you have not yet completed? _______________
___________________________________________________________________________________

Have you ever received any kind of TMJ (jaw joint) therapy or surgery? ___________________________

If so, please describe and give dates: _____________________________________________________

Do you ___ clench ___ grind you teeth? If so, ___ Day ___ Night

Do you chew your fingernails, or pencils or pens? ____________________________________________

Do you regularly see a chiropractor or physical therapist? _______________________________________

If so, how often and for what condition(s)? _________________________________________________

Please list your recreational activities. Include any regular exercise that you do: ____________________
___________________________________________________________________________________

What is your height? _____ feet _____ inches Your weight? ________________

Have you ___ gained ___ lost weight recently? How much? _______ Over what period of time? _______

**Office Use Only:** BP: _____________ Pulse: _____________

*Forms Revised 4/07*

SNORING/SLEEP APNEA QUESTIONNAIRE

1. How long have you been aware of snoring? ____________________
2. Has snoring caused problems for friends or relatives? ____________________
3. Have you been told your breathing stops while asleep? ____________________
4. Have you been told you move around a lot in your sleep? ____________________
5. Do you have any difficulty falling asleep at night? ____________________
6. About how many hours of sleep per night do you get? ____________________
7. Do you wake during the night? ________ If so, about how many times? ____________
8. Do you usually wake feeling refreshed in the morning? ____________________
9. Do you often wake up with a headache? ____________________
10. Will a small amount of alcohol give you a hangover? ____________________
11. Do you usually sleep on your side, back, or stomach? ____________________
12. Do you feel sleepy during the day __ frequently __ occasionally __ never
13. Have you ever fallen asleep while driving? ____________________
14. What other doctors have you seen about your snoring or sleep apnea? ____________________

    ________________________________________
15. Have you had an overnight sleep study done?______ If so, when?__________________

    Results of study? ____________________
16. What treatment have you had, and how successful has it been? ____________________

    ________________________________________

    ________________________________________
17. Do you have trouble breathing through your nose? ____________________
18. Is there anything else you would like us to know? ____________________

    ________________________________________

Name ____________________ Date ____________________ 

RVH _____ MTM _____ Asst. _____

*Revised 3/08*

**Insurance Information—Please Read!**

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **you** contact your insurance company **prior to your first visit in our office**. We certainly are happy to answer any insurance questions you may have, but please understand, MN Craniofacial Center Midway can only assist you and cannot guarantee payment from your insurance company.

**Please call your medical insurance company for the following information:**

**Non-Surgical Sleep Apnea Benefits:**

1. Do I have a deductible? Yes or No
2. How much of the deductible has been met? ____________________
3. Do I need a Prior Authorization for:
   - A: DME (Durable Medical Equipment)? Yes or No
     (Give DME CODE **E0486** to your insurance representative)
   - B: Physical Therapy Yes or No
4. Do I have an office copayment for each visit? Yes or No
5. How much is the office copayment? ________________
6. What percentage of the fee do I pay for the following:
   - A. X-Rays: ________________
   - B. Office Visits: ________________
   - C. DME (Durable Medical Equipment): _______________
   - D. Physical Therapy: ___________________

**Repair Charges:** Repair charges for broken oral appliances are the patient's responsibility to pay and the amount will vary, depending on the type of repair needed. Repair charges are not a covered service by your insurance company.

I have read and I understand my financial responsibility as stated above. I authorize direct payment of benefits from my insurance company to MN Craniofacial Center Midway, P.A.

Signature of Insured, or of Responsible Party if Patient is a Minor:

_______________________________________ Date: ______________

Witness ___________________________________ Date: ______________