

## **Introduction Letter to Patients**

Dear Patient,

Your sleep physician has referred you to my office. Your referring physician feels you might benefit from an intra-oral appliance which is designed to improve your breathing during sleep by advancing your lower jaw or holding your tongue forward. This movement helps to open the airway space which can reduce snoring and sleep apnea in many cases. We cannot guarantee that this device will be successful for all patients because there are many factors involved in sleep apnea

Patients who have been diagnosed as having sleep apnea should have routine visits to their physician or sleep disorders center. Moderate or severe obstructive sleep apnea is a potentially life threatening disease, and periodic monitoring of the disease is important. The intra-oral sleep apnea appliance does not cure snoring or sleep apnea, but it is designed to reduce snoring and apneic episodes while it is being worn. If your physician has suggested a change in sleeping position or weight loss these actions are important and are to be accomplished IN ADDITION to using the intra-oral device it is best to avoid alcohol, hypnotic or sedative drugs within 3-4 hours of going to bed.

Prior to the fabrication of any intra-oral device, you must have a consultation appointment to evaluate your oral condition as well as to discuss possible choices of treatment. If you require new fillings, crowns (caps), implant placement, or periodontal therapy, these procedures should be completed BEFORE the appliance is made. Any change in your dentition may require construction of a new device.

The first step may require you to have cephalometric x-ray pictures taken to determine the size of various oral structures. These films and a clinical examination will help determine if you can expect to be helped by an intra-oral sleep apnea device. Normally three to four appointments are required to fabricate the appliance, followed by appointments to adjust the fit of the device and evaluate its degree of effectiveness. The fit, wear and comfort of the appliance will be evaluated as the patient deems necessary.

When you come to your evaluation appointment please bring the following items:

1. Recent x-ray pictures from your dentist's office (for the previous 3 years, or most recent, originals please)
2. A copy of your sleep study report and the doctor's referral letter or prescription
3. Any authorization forms your medical insurer may require for coverage

If you normally premedicate for a dental appointment, please take your antibiotics as if this were a normal dental appointment. If you are unsure about premedication, please call your primary care physician.

4. If you wear a mouth piece of any sort (orthodontic retainer, night guard, etc.) please bring it with you to your appointment.

Most insurance companies will pay for oral appliances to treat obstructive sleep apnea, but may be very strict in their definition of 'sleep apnea'. You may wish to check with your insurer prior to your appointment. There is no specific billing code and most insurance companies make up their own. Many use "S8260".

Please read all enclosures, complete **AND SIGN** the enclosed forms and bring them with you to your appointment. Any questions you may have can be answered during the appointments necessary to fabricate your oral appliance.

# WELCOME

*We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## Patient Information - Adult

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
First Middle Last

Nickname (if preferred) \_\_\_\_\_ Male Female

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Home Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Street

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

General Dentist \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Have we treated another member of your family? YES NO If YES, Name \_\_\_\_\_  
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Have you visited an orthodontist before? YES NO If YES, for what reason? \_\_\_\_\_

Anything you would like to discuss with the doctor in private? YES NO

## Insurance Information

Marital Status      Single      Married      Widowed      Divorced      Separated      Domestic Partner

### Primary

Insurance Company Name \_\_\_\_\_ Insurance Company Phone \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Group or Plan \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

### Secondary

Insurance Company Name \_\_\_\_\_ Insurance Company Phone \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Group or Plan \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

## Dental and Medical History

Are you currently under the care of a physician?    YES    NO    If YES, for what reason? \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

History of major illness?    YES    NO    If YES, please describe \_\_\_\_\_

Any sensitivities or allergies?    YES    NO    If YES, please list \_\_\_\_\_

Currently taking any medications?    YES    NO    If YES, please list \_\_\_\_\_ Amount/Dose \_\_\_\_\_

Have you been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	High Blood Pressure

Do you require antibiotics before dental treatment?    YES    NO    If YES, explain \_\_\_\_\_

Have there been injuries to your face, mouth or chin?    YES    NO

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD)    YES    NO

Do/Did you have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Chronic Mouth Breathing	Speech Problems	Chewing/Eating Problems

## Signature

**I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.**

**I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Prescription For Oral Appliance Therapy for Obstructive Sleep Apnea\***

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Office Address: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Patient Telephone: \_\_\_\_\_

**Prescription to be filled by:  
C. Edgar Davila, D.D.S., M.S.**

**www.tampasmiles.net**

Credentialed by the Academy of Dental Sleep Medicine  
Board Certified Prosthodontist

**4712 N. Armenia Ave. Ste 100, Tampa, FL 33603**

Appointment Line: 813-872-9313 FAX: 813354-9446

The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have:

- Obstructive sleep apnea or Severity \_\_\_\_\_  
 Simple Snoring.

This patient is :

- Intolerant of CPAP therapy  
 Is not a candidate for CPAP therapy

Explanation (if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The patient is being sent for OA therapy with:

- The appliance chosen by Dr. Davila and the patient as most suitable  
 A \_\_\_\_\_ appliance (specific name)

Signature of referring physician:

\_\_\_\_\_  
**\*As a physician, I deem this therapy to be medically necessary.**

Date: \_\_\_\_\_

Obstructive Sleep Apnea is a medical condition that tends to become more severe with time, and requires periodic re-evaluation by a qualified physician.

Oral Appliance Therapy is less effective in controlling this disease than CPAP, and patients referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea.

Copies of Sleep Studies with full report are required by Dr. Davila for appropriate care and to obtain medical insurance coverage.

**Original Prescription MUST be mailed or delivered to Dr. Davila**

**Affidavit of Intolerance to CPAP**

**(Continuous Positive Air Pressure)**

I have attempted to use nasal CPAP to manage my sleep disordered breathing (obstructive sleep apnea) and find it intolerable to use on a regular basis due to the following reason (s):

- CPAP is not effective in controlling my symptoms.
- I am unable to sleep with the CPAP equipment in place.
- The noise from the device disturbs my sleep or my bed partner's sleep.
- I cannot find a comfortable mask.
- The mask leaks.
- I develop sinus / throat / ear / lung infections.
- I am allergic to materials in the mask and head straps.
- Claustrophobia
- I unconsciously remove the CPAP apparatus at night.
- The pressure of the mask and straps causes tissue breakdown
- My job and/or lifestyle prevent this form of therapy (e.g. Active Army / National Guard duty)
- Prior throat surgery made CPAP intolerable.
- Other \_\_\_\_\_

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of OSA, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## Questionnaire For Snoring/ Sleep Apnea

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

### The 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 in 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

<b>Situation:</b>	<b>Chance of dozing</b>
Sitting and reading _____	
Watching TV _____	
Sitting, inactive in a public place( e.g. movie 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 the car, while stopped for a few minutes in traffic _____	
<b>Total Score</b>	_____

### Behavior During Sleep

Use the following scale to choose the most appropriate number for each situation:

- 0= never during a usual night
- 1= less than once a week
- 2= once to about half the nights/ week
- 3= half the nights to almost always
- 4= almost always or every night
- ?= don't know or haven't been told \_\_\_\_\_

During your usual sleep, you have noticed or have been told you do the following:	
( 0 - 4, ?)	
Snore loudly _____	
Stop breathing _____	
Choke, struggle for breath _____	
Toss and turn frequently _____	
Wake up with a headache _____	
Usual number hours of sleep / night _____	
Number of times you rise to use the toilet _____	