COMPREHENSIVE HEALTH QUESTIONNAIRE

General Information

Patient Name: Date:

(First) (Middle) (Last)

Address:

(Street) (City) (State) (Zip)

Best way to reach you? Home Phone

Cell Phone: Work Phone:

Email:

Date of Birth: Age: Sex: ☐ Male ☐ Female

Height:_____ Weight:_____lbs. Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married/Partner

SSN: Occupation:

Emergency Contact: Relationship: Phone Number:

Referring Physician: Primary Care Physician:

Pulmonologist:

Current Medical Conditions

Diagnosis	Year	Treating Physician

Hospitalizations / Surgeries List (*Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Diagnosis	Year	Treating Physician

Current Medications (*Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

Medication	Reason	Dosage	How often

Allergies List: ☐ *No Known Drug Allergies*

EPWORTH SLEEPINESS SCALE

PATIENT NAME:_____ **DOB:**_____

In the absence of caffeine, energy drinks, etc., how likely are you on a scale of **0 - 3** to doze off or fall asleep in the following situations, in contrast to feeling just tired?:

0 = Would **Never** Doze

1 = **Slight** Chance of Dozing

2 = **Moderate** Chance of Dozing

3 = **High** Chance of Dozing

Scenarios:	**Chance Of Dozing**
1. Sitting and reading.	
2. Watching TV.	
3. Sitting inactive in a public place (e.g. a theater or a meeting).	
4. As a passenger in a car for an hour without a break.	
5. Lying down to rest in the afternoon when circumstances permit.	
6. Sitting and talking to someone.	
7. Sitting quietly after lunch without alcohol.	
8. In a car while stopped for a few minutes in traffic.	
TOTAL:	0

HEALTH QUESTIONS

PATIENT NAME:_____ **DOB:**_____

Medical History Screening: Do you have or have you had:

- ☐ High Blood Pressure / Hypertension
- ☐ Pulmonary Disease
- ☐ Congestive Heart Failure
- ☐ Heart Disease / Heart Attack
- ☐ Diabetes
- ☐ Morning Headaches
- ☐ MEN: Erectile Dysfunction
- ☐ TMJ / TMD
- ☐ Chronic Lung Disease (COPD / Ashma)
- ☐ Depression / Mood Disorders
- ☐ History of Stroke(s)
- ☐ Sleep Apnea
- ☐ Nocturnal Acid Reflux
- ☐ Nocturia (nighttime trips to the bathroom)
- ☐ OTHER Conditions or Additional Details: _____

_____

_____

_____

_____

Sleep History Screening: Do you have or have you had:

- ☐ BMI Higher Than 28
- ☐ Choking Or Gasping During Sleep
- ☐ Disturbed, Restless, or Un-Refreshed Sleep
- ☐ Frequent Arousals / Awakening From Sleep
- ☐ Snoring
- ☐ Fragmented Sleep
- ☐ Mouth Breathing

AFFIDAVIT FOR INTOLERANCE OR NON-COMPLIANCE TO CPAP

PATIENT NAME:_____ **DOB:**_____

I find CPAP intolerable to use on a regular basis due to the following reasons:

- ☐ I am unable to sleep with CPAP equipment in place
- ☐ The noise from the device disturbs my sleep or my bed partners 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 Armed Services / Nat. Guard)
- ☐ Prior throat surgery made CPAP intolerable
- ☐ CPAP was ineffective in controlling my symptoms
- ☐ OTHER: _____

_____

I have never worn a CPAP and refuse to wear one because:

- ☐ Declined CPAP therapy
- ☐ Claustrophobia
- ☐ I travel and refuse to carry a CPAP machine and hose
- ☐ I cannot have my movement restricted while sleeping
- ☐ Latex allergy
- ☐ 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 and would prefer to use oral appliance therapy.

_____ _____

Signature **Date**

Informed Consent for the Treatment of Sleep-Related Breathing Disorders with Oral Appliance Therapy

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy (OAT) for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder.

A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, continuous positive airway pressure (CPAP) and various surgeries. The risks and benefits of these alternative treatments should be discussed with your healthcare provider.

It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, and consent to performance of oral appliance therapy, please sign and date this form below. You will receive a copy.

Signature: _____ Date: _____

Print Name: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	**Date of Birth**	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ **Date:** _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Notice of Privacy Practices Effective January 1, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY:

Questions? Please contact our Privacy Office at the address/ phone number at the end of this notice.

Who Will Follow This Notice:

We provide health care to patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All contracted service partners for sleep and DME services.
- Any healthcare professional authorized to enter information into your chart, including practicing physicians and other credentialed individuals that participate with us in providing care and services.
- Any business associate or partner with whom we share health information.

Our Pledge to You:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in order to provide quality care and to comply with legal requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office.

We Are Required By Law To:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the current notice.

Changes To This Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If there is a significant change in our policies, we will change our notice and post the new version in areas of the facilities generally accessible by patients and their families. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How We May Use And Disclose Medical Information About You:

- We may use and disclose medical information about you with your consent or with the consent of others who are legally permitted to consent on your behalf for treatment (e.g., sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (e.g., sending billing information to your insurance company or Medicare); and to support health care operations (e.g., comparing patient data to improve treatment methods.)

- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, birth, death, abuse or neglect and domestic reporting, health oversight audits or inspections, qualified research studies, funeral arrangements and organ donation, workers' compensation purposes, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and other emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, e.g., regarding inmates in their custody, or in response to valid judicial or administrative orders.

Notice of Privacy Practices Effective January 1, 2026 (continued)

How We May Use And Disclose Medical Information About You (continued):

- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you,
- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Other Uses Of Medical Information:

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your Rights Regarding Medical Information About You:

- In most cases, you or your personal representative have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after your date of service. You may receive the list in paper or electronic form. The first disclosure list request in a
  12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.
- All written requests or appeals should be submitted to our Privacy Office listed below:

Complaints:

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office.
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address.
- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Acknowledgment of Notice of Privacy Practices

The above notice describes how medical information about you may be used and disclosed and how you can get access to information. I have received a copy of this office's Notice of Privacy Practices.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

_____

Print Name

_____

Signature

_____

Date

OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

_____

_____

_____