Northwest
SNORING
CENTER
Dedicated Sleep

Thank you for your interest in obtaining an oral appliance for snoring and sleep apnea. Enclosed are the necessary forms to be filled out and returned to start the paperwork process.

Once all forms are returned, we can start your pre-verification. Please call/email the office should you have any questions.

Phone: 208 667-4551
Email: Drjohnsoninfo@gmail.com

Return the following information:

1. New Patient Questionnaire
2. Copy of medical insurance card/s front and back
3. Signed HIPAA Consent
4. Signed Affidavit for Intolerance to CPAP, if applicable.
5. Signed Records Release
6. Overnight sleep study, if you have one.
7. Signed Referral Form from your Primary Care Physician
8. Signed ABN (Medicare ONLY)

Thank you,

Dr. Donald Johnson DDS

Sleep Well!
114 W. Neider ave Coeur d' Alene, Idaho 83815
Phone: (208)667-4551 Fax: (866)683-6479
Drjohnsoninfo@gmail.com

Northwest
SNORING CENTER

Dedicated Sl...

Patient Information:

First Name:_____MI:_____Last Name:_____

Home Phone (____) _____-_____Cell (_____) _____-_____Work Ph: (_____) _____-_____
Email Address: _____
Home Address: _____
City:_____State:_____Zip:_____Gender: ___Male ___Female

Date of Birth: MM/DD/YYYY
_____/_____/_____

Social Security # (SSN) _____-____-_____

Height: Feet_____ Inches _____ Marital Status: ___Married ___Minor ___Single___Partner
Weight:_____

Spouse/Parent/Guardian:_____Phone:_____
Emergency Contact: Name:_____
Relationship:_____Phone: _____

Referred by: _____

Employer Information:

Employer: _____
Phone: _____Fax: _____
Address:_____City:_____
State:_____Zip:_____

What is the main reason you are seeking treatment?

_____

_____

_____

Sleep Medicine
114 W. Neider ave Coeur d' Alene, Idaho 83815
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Primary Health Insurance:

Patient's Relationship to Primary Insured: ____Self ____Spouse ____Child ____Other
Name of Insured: First:_____MI_____Last_____
Insured DOB: (MM/DD/YYYY) _____/_____/_____
Insurance Company:_____Insurance ID: _____
Group #: _____ Plan Name and/or #:_____

Insurance Company Address: _____City: _____
State: _____ Zip: _____Phone: _____Fax:_____

Email:_____

Please bring your insurance card/s AND picture ID so we can photocopy.

Secondary Health Insurance:

Do you have secondary insurance? _____Yes _____No
If yes, please complete this section

Patient's relationship to insured: _____Self _____Spouse _____Child _____Other
Name of Insured: First: _____MI_____Last_____
Insured DOB: (MM/DD/YYYY) _____/ _____/ _____
Insurance Company: _____Insurance ID: _____
Group #: _____Plane Name and/or #: _____
Insurance Company Address: _____City: _____
State: _____Zip: _____
Phone: _____Fax: _____
Email: _____

[illegible]
114 W. Neider ave Coeur d' Alene, Idaho 83815
Phone: (208)667-4551 Fax: (866)683-6479
D.[illegible]info@gmail.com

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SNORING CENTER
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Medical Contacts: *(Needed to communicate treatment progress. Please be thorough to save us time, the less time looking for this information. Thank you!)*

Primary-Care-Physician: _____ Address:
City:_____ State:_____ Zip:_____ Phone:_____ Fax:_____

ENT: _____
Address: _____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

Sleep-Physician: _____ Address:
City:_____ State:_____ Zip:_____ Phone: _____ Fax:_____

Dentist: _____ Address:
City:_____ State:_____ Zip:_____ Phone:_____ Fax:_____

Other MD: _____
Address: _____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

Other MD: _____
Address: _____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

What is the main reason you are seeking treatment?

_____
_____
_____
_____
_____

Sleep Well
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Northwest SNORING CENTER

Northwest Snoring Center Patient Questionnaire

EPWORTH SLEEPINESS SCALE

Sitting and Reading	_____
Watching TV	_____
Sitting inactive in public place (theater)	_____
As a car passenger for an hour without a break	_____
Lying down in the afternoon to rest	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped at a traffic light	_____

0 = No chance of dozing
1 = Slight Chance of dozing
2 = Moderate Chance of dozing
3 = High Chance of dozing

TOTAL = _____

THORNTON SNORING SCALE

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from home	_____

0 = Never
1 = 1 night/week
2 = 2-3 nights/week
3 = 4+ nights/week

TOTAL = _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

_____

Do you have other complaints?

- ☐ Frequent snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other: _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

Subjective Signs and Symptoms

Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Have you been told you snore? YES / NO / SOMETIMES

Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

Do you have a bed partner? YES / NO / SOMETIMES **Do you sleep in the same room?** YES / NO

How many times per night does your bedtime partner notice you stop breathing?

SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER

Northwest SNORING CENTER

Northwest Snoring Center Patient Questionnaire

Have you ever had a sleep study? YES NO
If YES, where and when? _____ **Date:** _____

Have you tried CPAP? YES NO
Are you currently using CPAP? YES NO
If YES, how many nights per week do you wear it? _____/ 7 Nights
When you wear your CPAP, how many hours per night do you wear it? _____hours per night

If you use or have used CPAP, what are your chief complaints about CPAP?

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort from the straps or headgear
- ☐ Decrease sleep quality or interrupted sleep from CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI / stomach / intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ The device causes irritation due to air leaks
- ☐ Other:

_____
_____

Are you currently wearing a dental device? YES NO
Have you previously tried a dental device? YES NO
If YES, was it Over the Counter (OTC)? YES NO
Was it fabricated by a dentist? YES NO **If YES, who fabricated it?** _____

If applicable, please describe your previous dental device experience:

_____

Have you ever had surgery for snoring or sleep apnea? YES NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.

_____
_____
_____

Northwest SNORING CENTER

Northwest Snoring Center Patient Questionnaire

PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures? YES NO
If YES, what medication(s) and why do you require it? _____

ALLERGENS -- Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

_____

MEDICATIONS -- Please list all medications you are currently taking:

_____

MEDICAL HISTORY – Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

_____

_____

_____

Dental History

How would you describe your dental health? EXCELLENT GOOD FAIR POOR
Have you ever had teeth extracted? YES NO → **If YES, please describe** _____
Do you wear removable partials? YES NO
Do you wear full dentures? YES NO
Have you ever worn braces (orthodontics)? YES NO → **If YES, date completed:** _____
Does your TMJ (jaw joint) click or pop? YES NO → **Do you have pain in this joint?** YES NO
Have you had TMJ (jaw joint) surgery? YES NO
Have you ever had gum problems? YES NO → **If YES, have you ever had gum surgery?** YES NO
Do you have dry mouth? YES NO
Have you ever had an injury to your head, face, neck, or mouth? YES NO
Are you planning to have dental work done in the near future? YES NO
Do you clench or grind your teeth? YES NO
If you answered YES to any question above, please briefly describe your answer here:

_____

_____

Family History

Have genetic members of your family had:
Heart Disease? YES NO **High Blood Pressure?** YES NO **Diabetes?** YES NO
Have genetic members of your family been diagnosed or treated for a sleep disorder? YES NO
How often do you consume alcohol within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
How often do you take sedatives within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
How often do you consume caffeine within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never
Do you smoke? YES NO **If YES, how many packs per day?** _____
Do you use chewing tobacco? YES NO **If YES, how many times per day?** _____

PATIENT SIGNATURE

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.
Patient or Guardian Signature: _____ Date: _____

Statement of Therapy

- ❑ **I prefer to use an oral appliance treatment over CPAP treatment.**

- ❑ **I am CPAP intolerant for the following reasons:**
- ❑ Mask Leaks
- ❑ An Inability to get the Mask to Fit Properly
- ❑ Discomfort Caused by the Straps and Headgear
- ❑ Disturbed or Interrupted Sleep Caused by the Presence of the Device
- ❑ Noise From the Device Disturbing Sleep or Bed/Partner's Sleep
- ❑ CPAP Restricted Movements During Sleep
- ❑ Latex Allergy
- ❑ Claustrophobic Associations
- ❑ An Unconscious Need to Remove the CPAP Apparatus at Night
- ❑ I Would Like to Use Oral Appliance Therapy in Conjunction with CPAP Therapy to Reduce the CPAP Pressure.

- ❑ Other _____

Patient Name: _____

Patient Signature: _____

Sleep Health History

Patient Name: _____ DOB: _____

Associated Comorbidities

Hypertension *High Blood Pressure*	Y	N	Heart Disease	Y	N
			Mood Disorders	Y	N
History of Stroke	Y	N	Insomnia	Y	N
Type 2 Diabetes	Y	N	Impaired Cognition	Y	N

Epworth Sleepiness Scale

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total _____

Patient Signature: _____ Date: _____

Northwest
SNORING
CENTER

Dedicated

Financial Acknowledgment

Assignment and Release for patients with Insurance

I certify that I have insurance coverage and assign directly to **Dr. Donald Johnson** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and that the pre-verification of benefits does not guarantee payment. I authorize the use of my signature on all insurance submissions.

The above named provider may use my health care information and may disclose such information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature: _____ Date: _____

All patients please sign below

There will be a charge of $1500. for a replacement appliance, due to accidental loss or negligent misuse. ***Replacement of an oral appliance due to loss or negligence is a non-covered insurance benefit.***

In consideration of service rendered to me by this office, I accept full financial responsibility for all charges.

Signature: _____ Date: _____

114 W. Neider ave Coeur d' Alene, Idaho 83815
Phone: (208)667-4551 Fax: (866)683-6479
Drjohnsoninfo@gmail.com

Northwest
SNORING
CENTER

Dedicated

HIPAA Consent

How we collect information about you: On behalf of Northwest Snoring Center; we collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that are either required by law, or necessary to process claims or other requests.

What we do NOT do with your information: Information about your financial situation and your medical/dental condition, or the treatment and care that we provide you, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend or disseminate any information about our patients or responsible financial party, that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent.

How we do use your information: Any personal information about your health or finances, including x-rays and chart notes, are only used as is reasonably necessary, to process your dental or medical claims. In addition, this information will be shared with medical or dental product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical or dental information is accurate; determine the type of medical or dental supplies or any health care services you need. And to communicate the results of tests or findings to other health care providers on your behalf.

In the event your information is requested by law enforcement for any reason, your nonmedical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Signed:_____ Date:_____

Stacy Wall
114 W. Neider ave Coeur d' Alene, Idaho 83815
Phone: (208)667-4551 Fax: (866)683-6479
Drjohnsoninfo@gmail.com

PATIENT MEDICAL RECORDS RELEASE FORM

Date Requested:_____ Date Received:_____

This office coordinates treatment with your healthcare providers to help ensure maximum benefit to you. Please sign this record release form on the signature line at the bottom so we can retrieve medical records related to your sleep disordered breathing.

To:_____ FAX:_____

From: Dr. Donald Johnson, DDS, 114 W. Neider Ave., Coeur d'Alene, ID 83815
Phone: (208) 667-4551 FAX: (866) 683-6479

We would like to request a copy of the baseline PSG or HST, oximetry studies, Office notes on sleep and the patient's most recent CPAP titration study.

Patient Name:_____

Patient Date of Birth:_____/_____/_____

PLEASE FAX TO:(866) 683-6479 or EMAIL TO: DRJOHNSONINFO@GMAIL.COM

I request and authorize Dr. Donald Johnson, DDS, to obtain my medical records. A copy of this authorization may be used with the same effectiveness as an original.

Patient Signature:_____ Date:____/____/_____

Comments:_____

_____

Northwest SNORING CENTER

Physician Referral/Letter Of Medical Necessity

DATE_____

Patient Name:_____ DOB_____

Patient Phone:_____ Private Insurance___ Medicare___

Order/Referred By:_____

Order Physician Phone_____Fax:_____

_____Patient exhibits symptoms of possible Obstructive Sleep Apnea & **HAS NOT BEEN DIAGNOSED**. Consultation suggested with Dr. Johnson to determine appropriate testing. Treat with Oral Appliance Therapy (E0486) after appropriate diagnosis of OSA (G47.33) which I concur is **medically necessary**.

___Loud Snoring ____Witnessed apnea ____Excessive daytime sleepiness ____Unrefreshed feeling in AM
___Other _____

___Patient has previously been diagnosed with OSA (G47.33) and is intolerant to PAP therapy. Evaluate and treat with Oral Appliance Therapy (E0486) which I concur is **medically necessary**.

___Patient has previously been diagnosed with OSA (G47.33) and requests a dental device. Evaluate and treat with Oral Appliance Therapy (E0486) which I concur is **medically necessary**.

___**I concur that Oral Appliance Therapy (E0486) is medically necessary.**

Comments _____

PLEASE FAX to (866) 683-6479 or (866) 488-2537

Physician Signature: _____Date _____

Sleep Well
114 W Neider ave. Coeur d' Alene, Idaho 83815
Phone:208-667-4551 FAX:866-683-6479
Email:DrJohnsoninfo@gmail.com

A. Notifier: Dr. Donald J. Johnson DDS, INC **MEDICARE ONLY**
114 W Neider Ave Coeur d' Alene Idaho 83815 208-667-4551

C. Patient ID#: **B. NAME:**

Advance Beneficiary Notice of Noncoverage (ABN)

Note: If Medicare doesn't pay for **D. Obstructive sleep apnea Oral Device and Titration therapy** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Obstructive sleep apnea Oral Device and Titration therapy** below.

WHAT YOU NEED TO DO NOW:

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Obstructive sleep apnea Oral Device and Titration therapy	**If the device is not determined to be medically necessary or Medicare determines that the C-pap Intolerance is not sufficient need for an oral device.**	**$6,500.00**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Obstructive sleep apnea Oral Device and Titration therapy listed above.
- **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Obstructive sleep apnea Oral Device and Titration therapy** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Obstructive sleep apnea Oral Device and Titration therapy** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. Obstructive sleep apnea Oral Device and Titration therapy** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: