Louly Dentistry Inc.

Patient Registration

Date ___/___/_____

First name_____Middle initial_____Last name_____

Sleep Physician Name _____

Responsible party (if someone other than patient) _____

Street address _____

City_____State_____Zip_____

Home phone _____Work phone _____Cell Phone _____

Sex: M____ F____

Date of Birth: ___/___/_____

Social security number: _____-_____-_____

Email_____ Height: Feet____ Inches____

Allow spouse to review records____

Family Dentist_____

Primary Medical Insurance Information

First name of insured_____Middle initial_____Last name_____

Insurance company_____ Phone #_____

Member ID_____ or Social security number: _____-_____-_____

Group #_____

Secondary Medical Insurance Information

First name of insured_____Middle initial_____Last name_____

Insurance company_____ Phone #_____

Member ID_____ or Social security number: _____-_____-_____

Group #_____

Patient signature _____

Date: ___/___/_____

LOULY
DENTISTRY

INSURANCE/ FINANCIAL POLICY

Welcome to our practice! We appreciate the opportunity to provide you with the highest quality of dental care in a warm and caring environment. We've provided this letter to answer questions you may have regarding our financial policies.

Insurance:

Our office will gladly submit your insurance claims for services rendered. We will work hard to ensure that you receive the maximum dental insurance benefits entitled to you. We do ask that you pay any applicable co-pay or deductible **at the time of service**. Our office staff can provide you with your estimated balance. Please remember that your insurance is a contract between you and the insurance company, not your dentist and the insurance company.

Though we will estimate your insurance benefits as close as possible, it is only an estimate. An insurance claim is normally processed within 30-60 days. Should the claim go unprocessed we may ask you to intercede on your behalf. All treatment fees are the responsibility of the patient. Should insurance not pay in a timely manner, the patient is responsible for the fee in full. We will, of course, provide you with all the necessary forms and information needed to pursue your insurance reimbursement.

Payment Options:

Our office coordinator will explain your treatment fees, estimated patient balance, and discuss methods of payment: cash, checks, Visa, MasterCard, and Discover. We also offer an outside financial service as an alternative financial option.

Late Charges:

A 1.5% late charge of your unpaid and owed balance may be assessed each month. Please realize that failure to keep your account current may result in your account being referred to a collection agency or a lawyer. In case of default of payment on this account, you agree to pay all collection and legal fees incurred in order to collect the current amount owed.

Returned Checks:

A returned check fee of $30.00 will be applied to each returned check. If we receive more than 2 returned checks, we will request all payments be made in cash, credit card or money order.

By signing below you acknowledge that you have read this document, understand the information presented, and have had all your questions answered satisfactorily.

Patient/Parent
Signature:_____Date:_____

LOULY DENTISTRY, INC.

Health insurance is a contract between you (the patient) and your insurance company

We will file your insurance and fight to get your benefits. We have been 95% successful in collecting from private insurances, Anthem, BCBS and Medicare.

I have read and understood the previous.

Patient's signature _____ Date _____

AMMAR C. LOULY, DDS-MSD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—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: Ammar Louly, DDS-MSD
Telephone: (317)869-0060 Fax: (317)869-0233
Address: 9602 E. Washington St. #A Indianapolis, IN 46229

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.

SIGNATURE

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 health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

LOULY
DENTISTRY

INFORMED CONSENT FOR THE TREATMENT OF SLEEP APNEA WITH ORAL APPLIANCE

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 your 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) utilizes a custom-made, adjustable FDA cleared appliance specifically made to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. In order to derive the benefits of OAT, the oral appliance must always be worn when you sleep.

Benefits of Oral Appliance Therapy

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. Additionally, durable medical equipment such as your oral appliance requires specific homecare, maintenance and periodic replacement.

Possible Risks, Side-Effects and Complications of Oral Appliance Therapy

With an oral appliance, some patients experience excessive drooling, 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. It is possible to experience dislodgment of dental restorations, such as fillings, crowns and dentures. 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 OAT is discontinued. These changes are likely to continue to worsen with continued use of the device.

It is mandatory for you to complete follow-up visits with the Dentist who provided your oral appliance to ensure proper fit and optimal positioning. If unusual symptoms or discomfort occur or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further. Follow-up assessments are necessary to assess your health and monitor your progress.

Once your oral appliance is in an optimal position, a post-adjustment assessment by your Physician is necessary to verify that the oral appliance is providing effective treatment.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include positive airway pressure (PAP) therapy, various surgical and implant procedures, and positional therapy (which prevents patients from sleeping on their back instead on their side). The risks and benefits of these alternative treatments should be discussed with your Physician who diagnosed your condition and prescribed treatment.

It is your decision to choose OAT alone or in combination with other treatments to treat your sleep-related breathing disorder. However, none of these may be completely effective for you.

It is your responsibility to report the occurrence of side effects and to address any questions to this office (address below), or to your Physician. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications and/or accidental injury.

Patient's Privacy and Confidentiality

I acknowledge receipt of the office's privacy policies. This includes a summary of the HIPAA federal law and the applicable state laws.

Patient Obligations and Acknowledgements

1. I understand the explanation of the proposed treatment. Further additional communication tools such as videos, pamphlets or articles may be available at my request.
2. I have read this document in its entirety and have had an opportunity to ask questions. Each of my questions has been answered to my satisfaction. If I do not understand this document, I have been offered this document in a different language or have been offered a language interpreter. My family alone is not acceptable to be my interpreter.
3. I agree that regularly scheduled follow-up appointments with my Dentist (oral appliance provider) are essential. These visits will attempt to minimize potential side effects and to maximize the likelihood of management of my OSA.
4. I understand that I must schedule a post-adjustment assessment with my Physician to verify that the oral appliance is providing effective treatment.
5. I will notify this office of any changes to the OAT, my teeth and my medical condition(s).
6. I understand that I must maintain my oral appliance through regularly scheduled follow-up appointments with my general dentist and my oral appliance provider dentist, if not the same.
7. I understand that if I discontinue OAT, I agree to inform and follow up with my Physician and Dentist (oral appliance provider).
8. I understand that refusing to participate and cooperate as stated herein will put my health at risk.
9. I consent to treatment with a custom-made, adjustable, FDA cleared oral appliance to be delivered and adjusted by my Dentist (oral appliance provider). I agree to follow all post-delivery and homecare instructions

Please sign and date this form below to confirm your agreement with the above statements. You will receive a copy of this document for your records, and it will be included in your patient records.

Patient Signature:_____ Date: _____

Print Name: _____

Signature:_____ Date: _____
Parent or Legal Guardian

Witness Signature:_____ Date: _____

Print Name: _____

Dentist Acknowledgement
Signature: _____ Date: _____

Print Name: _____

Louly Dentistry Inc.
9602 East Washington St
#A, Indianapolis, Indiana. 46229
(317) 869-0000

Snore No More Indiana
1600 North 3rd st.
Terre Haute, Indiana. 47804
(812) 881-5300

Louly Dentistry Inc.

Medical History Questionnaire

Mark all that apply

Allergens

___None
___Antibiotics
___Aspirin
___Barbiturates
___Codeine
___Iodine
___Latex
___Local anesthetics
___Metals
___Penicillin
___Plastic
___Sedatives
___Sleeping pills
___Sulfa drugs
Other:_____

Current Medication

Medication Name	Dosage/Frequency	Reason

Medical History

___Acid Reflux
___Arthritis
___Bleeding easily
___Bruising easily
___Chronic fatigue
___Coronary heart disease
___Diabetes
___Emphysema
___Glaucoma
___Heart murmur
___Hemophilia
___Hypoglycemia
___Ischemic heart disease
___Meniere's disease
___Multiple sclerosis
___Nasal allergies
___Osteoporosis
___Radiation treatment
___Sinus problems
___Tendency for ear infections
___Tumors
___Anemia
- ___Autoimmune disorder
- ___High blood pressure
- ___Cancer
- ___Chronic pain
- ___Current pregnancy
- ___Difficulty sleeping
- ___Excessive daytime sleepiness
- ___Gout
- ___Heart valve replacement

___Hepatitis
- ___Immune system disorder
- ___Kidney problems

___Mitral valve problem
- ___Multiple sclerosis
- ___Neuralgia
- ___Prior orthodontic treatment
- ___Rheumatic fever
- ___Sleep apnea
- ___Thyroid disorder
- ___Urinary disorders

___Atherosclerosis
- ___Asthma
- ___Low blood pressure
- ___Chemotherapy
- ___COPD

___Depression
___Dizziness
- ___Fibromyalgia
- ___Heart attack
- ___Heart pacemaker

___Hypertension
___Insomnia
- ___Liver disease

___Mood disorder
- ___Muscular dystrophy
- ___Osteoarthritis
- ___Parkinson's disease
- ___Rheumatoid arthritis
- ___Stroke
- ___Tuberculosis

Other:_____

Surgical Operations

___Appendectomy
___Back
___Ear
___Gallbladder
___Heart
___Hernia repair
___Lung
___Nasal
___Thyroid
___Tonsillectomy
___Uvulectomy
___Periodontal
Other:_____
_____

Louly Dentistry Inc.

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things 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

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre 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 the traffic	

THANK YOU FOR YOUR COOPERATION

Louly Dentistry Inc.

Affidavit for Intolerance or Non Compliance to CPAP

I, _____, have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- ☐ 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
- ☐ CPAP does not seem to be effective
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night
- ☐ Other _____

Because of my intolerance / inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Signed: _____

Dated: _____

Louly Dentistry Inc.