VIVOS

Patient Name: _____

Patient Sex: M F Birthday _____ / _____ / _____ Marital Status: _____

Address: _____ Apt #: _____

City & State: _____ Zip:_____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Ext: _____

E-Mail Address: _____

Pharmacy Name: _____

Main Cross Streets: _____

Pharmacy Phone # _____

Social Security #: _____

Driver's License #: _____ State: _____

Employer: _____

Employer Address: _____

Emergency Contact: _____ Phone # _____

Relationship to Patient: _____

GUARANTOR INFORMATION – IF DIFFERENT FROM ABOVE

Guarantor Name: _____ Relationship to Pt: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone # _____

Employer: _____ Phone # _____

Employer Address: _____

Guarantor Social Security #: _____ Birthday: _____ / _____ / _____ Sex: ____

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INSURANCE INFORMATION
PRIMARY

Insurance Co Name: _____

Employer of Policy Holder: _____

Name of Policy Holder: _____

Relationship to Patient: _____

Insurance Claim Address: _____

Insurance Claim Phone # _____ Policy Holder Birthdate: _____ / _____/ _____ Sex: _____

Insurance ID # _____ Group # _____ Effective Date: _____

Secondary Insurance Co Name: _____

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insurance and any other health plan to the Vivos Breathing Wellness Center. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges and I authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signed: _____ Date: _____

VIVOS

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your Vivos dentist, Vivos office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a durable medical equipment company that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protected health information be disclosed to obtain approval or authorization.

Healthcare Operations: We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may also call you by name in the waiting room when your doctor is ready to see you.

We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative

Name of Personal Representative

_____ _____

VIVOS

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ Spouse _____
_____ Child(ren)_____
_____ Other_____
_____ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

Messages

Please call: _____ my home
_____ my work
_____ my cell: _____
_____ other: _____

If unable to reach me:

_____ You may leave a detailed message
_____ Please leave a message asking me to return your call
_____ Other _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

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Adult New Patient Registration & Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Chief Complaint: _____

SLEEP HISTORY

Lights Out: _____ ❑ AM ❑ PM Lights On: _____ ❑ AM ❑ PM

Number of awakenings during the night: _____ Trips to the bathroom during the night: _____

Do you take any sleep aids to help you sleep? ❑ Yes ❑ No If yes, what kind? _____

_____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do you have a history of any of the following? *(Check if "YES" to any of the following)*

- ❑ Difficulty falling asleep at night
- ❑ Snoring
- ❑ Witnessed apneas
- ❑ Gasping/choking during sleep
- ❑ Sweating/perspiring in sleep
- ❑ Drooling in sleep
- ❑ Dry mouth upon awakening
- ❑ Teeth grinding/clenching Sleep talking
- ❑ Heart palpitations
- ❑ GERD/reflux/heartburn
- ❑ Excessive daytime sleepiness
- ❑ Tired/fatigued during the daytime
- ❑ Nasal allergies/hay fever/nasal congestion
- ❑ Asthma
- ❑ TMJ pain/jaw discomfort
- ❑ Bedwetting
- ❑ Erectile dysfunction
- ❑ Decreased libido
- ❑ Hypertension/high blood pressure
- ❑ Depressed mood/irritability
- ❑ Anxiety/stressed out
- ❑ Difficulty with concentration
- ❑ Memory problems
- ❑ Cold hands/feet
- ❑ Chest pain/chest discomfort
- ❑ Shortness of breath during the day
- ❑ Acting out dreams
- ❑ Morning headaches
- ❑ Difficulty staying asleep
- ❑ Excessive movements in sleep
- ❑ Nightmares/bad dreams
- ❑ Sleep walking

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PAST MEDICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

ALLERGY HISTORY

❑ None Known ❑ YES, to: 1._____ 3._____

2._____ 4._____

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____# of cups of tea per day

_____ # cans or glasses of soda per day _____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol: ❑ None ❑ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

Tobacco: ❑ None ❑ Yes _____ # of packs per day _____ # of years

Recreational Drugs (such as marijuana or cocaine): ❑ None ❑ Yes

If yes, which ones? _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Children: ❑ No ❑ Yes How many? _____

Pets: ❑ No ❑ Yes How many? _____ What type of pet? _____

Do you have any children or pets that sleep in your bedroom? ❑ No ❑ Yes _____

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FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply and "no" to those that do not apply.):

- ❑ High blood pressure/hypertension
- ❑ Heart disease
- ❑ Stroke
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes
- ❑ Overweight/obesity
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Anxiety
- ❑ Chronic insomnia
- ❑ Restless legs syndrome
- ❑ Multiple sclerosis
- ❑ Sleep walking

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite: Sweats: ❑ Yes ❑ No
Fever: ❑ Yes ❑ No
Fatigue: ❑ Yes ❑ No
Weight Gain: ❑ Yes ❑ No
Weight Loss: ❑ Yes ❑ No

Gastrointestinal:

Heartburn/Indigestion: ❑ Yes ❑ No
Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No
Nausea/Vomiting: ❑ Yes ❑ No
Jaundice: ❑ Yes ❑ No
Abdominal Pain ❑ Yes ❑ No

Allergy/Immunology:

Sneezing: ❑ Yes ❑ No
Runny Nose: ❑ Yes ❑ No
Itchy Eyes or Nose: Hives: ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No
Double Vision: ❑ Yes ❑ No
Vision Loss: ❑ Yes ❑ No

Respiratory:

Cough: ❑ Yes ❑ No
Shortness of Breath: ❑ Yes ❑ No
Wheezing: ❑ Yes ❑ No
Poor Exercise Tolerance: ❑ Yes ❑ No

Genitourinary:

Bed Wetting: ❑ Yes ❑ No
Frequent Urination: ❑ Yes ❑ No
Difficulty Urinating: ❑ Yes ❑ No
Blood in Urine: ❑ Yes ❑ No

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No
Muscle Pain: ❑ Yes ❑ No
Red or Swollen Joints: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No
Sore Throat: ❑ Yes ❑ No
Sinus Congestion: ❑ Yes ❑ No
Hoarseness: ❑ Yes ❑ No

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Cardiac:

Palpitations: ❑ Yes ❑ No
Chest Pain: ❑ Yes ❑ No
Daytime Shortness of Breath: ❑ Yes ❑ No
Nighttime Shortness of Breath: ❑ Yes ❑ No
Ankle Swelling: ❑ Yes ❑ No

Neurologic:

Weakness: ❑ Yes ❑ No
Seizures: ❑ Yes ❑ No
Involuntary Tongue Biting: ❑ Yes ❑ No
Passing Out: ❑ Yes ❑ No
Dizziness: ❑ Yes ❑ No
Headaches: ❑ Yes ❑ No
Numbness: ❑ Yes ❑ No

Skin:

Unusual Moles: ❑ Yes ❑ No
Rash: ❑ Yes ❑ No
Dryness: ❑ Yes ❑ No

Hema/Lymph:

Unexplained Weight Loss: ❑ Yes ❑ No
Unusual Bleeding/Bruising: ❑ Yes ❑ No
Swollen Lymph Nodes: ❑ Yes ❑ No

Endocrine:

Weight Gain: ❑ Yes ❑ No
Heat Intolerance: ❑ Yes ❑ No
Excessive Thirst: ❑ Yes ❑ No
Constipation ❑ Yes ❑ No
Cold Intolerance: ❑ Yes ❑ No

Psych:

Excess Stress: ❑ Yes ❑ No
Memory Loss: ❑ Yes ❑ No
Difficulty with Focus ❑ Yes ❑ No
Trouble Concentrating ❑ Yes ❑ No
Hallucinations: ❑ Yes ❑ No
Nervousness or Anxiety: ❑ Yes ❑ No
Depressed Mood: ❑ Yes ❑ No

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION

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Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____ no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____ yes _____ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____ yes _____ no

Are you happy with your CPAP or Sleep Appliance? _____ yes _____ no

If you are not happy - why? _____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$

Berlin Questionnaire©
Sleep Apnea

Height (m) _____ Weight (kg) _____ Age _____ Male / Female

Please choose the correct response to each question.

Category 1

1. Do you snore?
□ a. Yes
□ b. No
□ c. Don't know

If you answered 'yes':

2. You snoring is:
□ a. Slightly louder than breathing
□ b. As loud as talking
□ c. Louder than talking

3. How often do you snore?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

4. Has your snoring ever bothered other people?
□ a. Yes
□ b. No
□ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ □ e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
□ a. Yes
□ b. No

If you answered 'yes':

9. How often does this occur?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

Category 3

10. Do you have high blood pressure?
□ Yes
□ No
□ Don't know

Scoring Berlin Questionnaire

The questionnaire consists of 3 categories related to the risk of having sleep apnea. Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores in the symptom categories.

Categories and Scoring:
Category 1: items 1, 2, 3, 4, and 5;
Item 1: if '**Yes**', assign **1 point**
Item 2: if '**c**' or '**d**' is the response, assign **1 point**
Item 3: if '**a**' or '**b**' is the response, assign **1 point**
Item 4: if '**a**' is the response, assign **1 point**
Item 5: if '**a**' or '**b**' is the response, assign **2 points**
Add points. *Category 1 is positive if the total score is 2 or more points.*

Category 2: items 6, 7, 8 (item 9 should be noted separately).
Item 6: if '**a**' or '**b**' is the response, assign **1 point**
Item 7: if '**a**' or '**b**' is the response, assign **1 point**
Item 8: if '**a**' is the response, assign **1 point**
Add points. *Category 2 is positive if the total score is 2 or more points.*

Category 3 is positive if the answer to item 10 is '**Yes**' or if the BMI of the patient is greater than 30kg/m2.
(BMI is defined as weight (kg) divided by height (m) squared, i.e.., kg/m2).

High Risk: if there are 2 or more categories where the score is positive.

Low Risk: if there is only 1 or no categories where the score is positive.

Additional Question: item 9 should be noted separately.

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Breathe new life.

INFORMED CONSENT FOR DNA/mRNA APPLIANCE THERAPY

You have been diagnosed with craniofacial underdevelopment. There are several options to treat this condition, including no treatment, treatment, consultation with a specialist in orthodontics or surgery.

What is DNA/MRNA /mRNA appliance therapy?

DNA/MRNA appliance therapy for midfacial development is a relatively new therapy, and not practiced by all dentists. DNA/MRNA appliance therapy has effectively treated many patients. There are no guarantees that DNA/MRNA appliance therapy will be effective for you, as everyone is different and there are many factors influencing the development of the maxilla. The full effect of the DNA/MRNA appliance is yet to be determined. It is important to recognize that even when therapy is effective, there may be a period of time before the DNA/MRNA appliance will give you maximum relief of symptoms. The DNA/MRNA appliance is a biomimetic appliance that tries to mimic normal function and, therefore, encourages normal development of the jaws. Just as your problem took a long time to fully develop, this technique can take a long time to resolve your problem. The standard protocol for development is approximately 18 months, but is directly affected by the severity of an individual patient's problem.

Side Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance use in general may include excessive salivation, difficulty swallowing (with the appliance in place), sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term changes in the bite. 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 changes in the bite that may be permanent, resulting from tooth movement, or jaw joint repositioning (which is the desired effect with appliance therapy). These complications may or may not be fully reversible once appliance therapy is discontinued. The desired effect of the DNA/MRNA /mRNA appliance specifically (in most cases) is to remodel the jaw bone, move the teeth and jaw position to enhance craniofacial development. If not fully achieved, restorative dental treatment, orthodontic intervention or other treatments may be required, for which you will be responsible.

Follow-Up Visits and Testing

Follow-up visits every few weeks or months in our office are mandatory to insure proper fit and to assure a healthy condition, as well as the maximum, timely development of your mouth and jaw. Following the approximate 16-36 months development protocol, scans and images are required to test the position of your jaw and teeth. Periodic photographic documentation is also required. From this point, depending on the amount of development, we will re-assess your case and may consider alternative treatment modalities or extending treatment time.

Damaged Appliances

There will be a fee for broken and/or damaged appliances. The fee will be dependent upon the scope of damage. In some cases, a new appliance may be indicated with an associated fee for fabrication.

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Alternative Treatments
Other accepted treatments for your condition include orthodontics by a specialist, and/or various surgeries. It is your decision to have chosen DNA/MRNA appliance therapy to treat your condition, and you are aware that it may not be completely effective for you. The DNA/MRNA appliance will not work if you do not wear it. It is your responsibility to report the occurrence of side effects and to address any questions to the doctor. Failure to treat your condition may lead to obstructive sleep apnea (which may already co-exist).

Do not sign this before you have read and understood it. You are entitled to an exact copy of the paper you sign.

I understand and accept any and all risks, known and unknown, involving the wearing of a DNA/MRNA appliance and I understand all the terms of this Informed Consent.

I consent to the release of my medical photos and radiographs for documentation and research purposes.

I hereby certify that I have read and received a copy of this document on the date listed below and that I have read the Informed Consent regarding my treatment.

I fully understand all the terms of Informed Consent.

Print Name of Patient_____

Signature of
Patient/Parent/Guardian_____Date_____

Signature of
Witness_____Date_____