MINNESOTA
CRANIOFACIAL
CENTER FOR TMJ & SLEEP TREATMENT

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Welcome to the Minnesota Craniofacial Center for TMJ & Sleep Treatment!

Snoring used to be considered a joke. Now we know that snoring can be a serious problem that affects family relationships, quality and appreciation of life, and cardiovascular health. When snoring progresses to become sleep apnea with frequent lapses in breathing during the night, the problem can even become life-threatening. Congratulations on having recognized that you have a physical problem that requires treatment!

Major advances have been made in sleep research. Treatment with oral appliances is very comfortable and effective for many people, for whom the only choice used to be surgery. Often, people comment that their first night's sleep with their oral appliance was the best night's sleep they have had in years!

Your first appointment will include an examination to determine if you are a candidate for oral appliance therapy, and we will explain your treatment choices to you. Some people need to be referred to a sleep center for further laboratory tests before an oral appliance can be constructed. We will discuss this possibility with you, also.

We have enclosed some registration forms. Please fill these out ahead of time and bring them to your first appointment. We look forward to meeting you, and to helping you sleep better!

Sincerely,

Kim Ledermann, DDS, MS

Kim Ledermann, D.D.S., M.S.
MINNESOTA CRANIOFACIAL CENTER, P.C.

SNORING/SLEEP APNEA QUESTIONNAIRE

1. How long have you been aware of snoring?_____
2. Has snoring caused problems for friends or relatives?_____
3. Have you been told your breathing stops while asleep?_____
4. Do you usually sleep on your side, back, or stomach? _____
5. Have you been told you move around a lot in your sleep?_____
6. Do you have any difficulty falling asleep at night?_____
7. About how many hours of sleep per night do you get?_____
8. Do you wake during the night?___ If so about how many times_____
9. Do you usually wake feeling refreshed in the morning?_____
10. Do you often wake up with a headache?_____
11. Will a small amount of alcohol give you a hangover?_____
12. Do you feel sleepy during the day __frequently __ occasionally __ never (Ep=__)
13. Have you ever fallen asleep while driving?_____
14. What other doctors have you seen about your snoring or sleep apnea? _____

    _____
15. What treatment have you had, and how successful has it been? _____

    _____

    _____
16. Have you had an overnight sleep study done?_____If so when?_____

    Results of study? _____
17. Do you have trouble breathing through your nose?_____
18. Is there anything else you would like us to know?_____

    _____

Patient Name: Appt date:
DOB:

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 recently, try to decide how they are likely to affect you. Use the following scale to choose the most appropriate number for each situation, and write the number in the blank:

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation:	**Chance of Dozing:**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place such as a theater 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 traffic	_____

Have you ever received a diagnosis of obstructive sleep apnea or another sleep breathing disorder? _____ Yes _____ No

If yes, are you receiving treatment for this disorder? _____ Yes _____ No

What treatment have you received? _____

If you are not receiving treatment, why not? _____

_____

Have you tried using continuous positive airway pressure (CPAP) to treat your symptoms?
_____ Yes _____ No If no, why not? _____

____ (check if true) I have attempted to use CPAP and find it intolerable to use on a regular basis for the following reason(s): _____
_____

Because of my inability to tolerate CPAP and my need to control the symptoms of obstructive sleep apnea, I wish to use oral appliance therapy.

Signed: _____ Date: _____

Patient Name: Appt date:
DOB:

PEDIATRIC SLEEP SCREENING

Fill out this form if you are a parent or guardian accompanying a child receiving treatment. Please complete it as accurately as possible. In our practice we are very interested in our patients' overall health, and orthodontic treatment in children can be an important part of managing health problems caused by sleep and breathing disorders.

Patient's name: _____ Age: _____

Form filled out by: _____

Date: _____

_____ While sleeping, does your child snore?

_____ While sleeping, does your child have heavy or loud breathing?

_____ While sleeping, does your child have trouble breathing or struggle to breathe?

_____ Have you ever seen your child stop breathing or hold his or her breath at night?

_____ Does your child wet the bed, sleepwalk or have night terrors (circle any)?

_____ Does your child clench or grind their teeth at night?

_____ Does your child tend to breathe through his or her mouth during the day?

_____ Does your child have a dry mouth on waking in the morning?

_____ Does your child wake up feeling tired in the morning?

_____ Does your child wake up with headaches?

_____ Is it hard to wake your child in the morning?

_____ Does your child have a problem with sleepiness during the day?

_____ Has a teacher or caregiver commented that your child appears sleepy or very active during the day? (circle one)

_____ Does your child often have difficulty organizing tasks and activities?

_____ Does your child have difficulty paying attention?

_____ Does your child have dark circles under his or her eyes?

_____ Does your child have crowded teeth or a misaligned bite?

_____ Did your child stop growing at a normal rate at any time since birth?

_____ Is your child overweight?

_____ Is your child very active?

_____ Does your child have significant emotional or behavioral issues?

Patient Medical & Insurance Information

Please list information for everyone involved in your care. We will send an examination report to each of these addresses, unless you request otherwise. Please use a black or blue pen.

Your Name: _____
Date of Birth: _____
Address: _____
City: _____
State: _____ Zip: _____
Home #: _____
Work #: _____
Cell #: _____
Email: _____
Employer: _____
Emergency Contact: _____
Phone #: _____
****

Whom may we thank for referring you to our office?

_____
****

Primary Health Insurance: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Subscriber _____
Subscriber DOB: _____
Policy/Group #: _____
ID # _____
****

Secondary Health Insurance: _____
Phone #: _____
Subscriber: _____
Subscriber DOB: _____
Policy/Group #: _____
ID #: _____
****

If your treatment is related to a motor vehicle accident, please fill in the following:

Auto Insurance: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
DOI: _____ Claim #: _____
Adjuster Name: _____
Phone #: _____
****

Attorney: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____

If Minor, Name of Responsible Party:

_____

I authorize sharing my *(check one or both)*
__ financial information / __ treatment information
with the following person:

_____
Signature: _____
****

Physician: _____
Clinic Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
****

Dentist: _____
Clinic Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
****

Chiropractor: _____
Clinic Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
****

Neurologist: _____
Clinic Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
****

Other Care Provider: _____
Clinic Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
****

If your treatment is related to a work injury, please fill in the following:

Other Insurance Info (Workers Comp/Personal Injury) Company Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Subscriber: _____ DOB: _____
Policy#: _____ID #: _____

Patient Name:
DOB:

Appt date:

Insurance Information—Please Read!

Please note that it is your responsibility to understand your insurance benefits and coverage. Filling out this form will help us give you the most accurate **estimation** of your benefits. We will submit to your insurance as a courtesy.

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **you** contact your insurance company **prior to your first visit in our office**. We certainly are happy to answer any insurance questions you may have, but please understand, MN Craniofacial Center can only assist you and cannot guarantee payment from your insurance company.

Please call your medical insurance company for the following information.

1. Do I have non-surgical sleep apnea benefits? Yes or No

2. Do I have a deductible? Yes or No
   How much is the deductible? _____
   How much of the deductible has been met? _____

3. Do I need a Prior Authorization for DME (Durable Medical Equipment)? Yes or No
   (Give DME CODE **E0486-Oral Sleep Apnea Appliance** to your insurance representative. If that code does not work try **21110**)

   Fax number to send prior authorization: _____

4. Copayments are due on the day of service. How much is my office copay? _____

5. Is a home sleep study covered? (Give code **95806**.) Yes or No
   What percentage of the fee do I owe? _____
   (MCC may recommend a home sleep study for follow-up purposes.)

6. Which of these services will be applied to my deductible, and what percentage of the fee do I pay for them:
   A. X-Rays: _____
   B. Office Visits: _____
   C. DME (Durable Medical Equipment): _____

Name of representative you spoke with _____ Date _____

Repair Charges: Repair charges for broken oral appliances are the patient's responsibility to pay and the amount will vary, depending on the type of repair needed. Repair charges are not a covered service by your insurance company.

Your insurance plan may require a referral from your primary care physician to be seen in our office. You are responsible for being aware of this and for obtaining this referral if it is required.

Patient Name: Appt date:
DOB:

Sleep Disorder Medical History

Welcome to our office! Today you will be given an examination regarding your suitability for an oral snoring and/or sleep apnea appliance. Records such as x-rays and diagnostic models may be necessary to form a complete diagnosis. Please answer these questions as completely as possible. Some of the material is repetitive, but it is necessary both to help us be thorough and to help you obtain any insurance benefits that may apply. Thank you for your help.

Name: _____ Age: _____ Today's Date: _____

Gender: ___ Male ___ Female

Please describe your chief complaints: _____

_____

Occupation: _____ Typical job duties: _____

Work schedule: _____

MEDICAL HISTORY: Do you have or have you ever had any of the following conditions?

Yes	No		Yes	No	
_____	_____	AIDS	_____	_____	Arthritis
_____	_____	Bleeding Problems	_____	_____	Bone Disorder
_____	_____	Cancer	_____	_____	Diabetes
_____	_____	Eating Disorder	_____	_____	Heart Disease
_____	_____	Hepatitis	_____	_____	High Blood Pressure
_____	_____	Intestinal Problems	_____	_____	Kidney Disease
_____	_____	Low Blood Pressure	_____	_____	Neurologic Problems
_____	_____	Stomach Problems	_____	_____	Tuberculosis
_____	_____	TMJ Clicking	_____	_____	TMJ Grating
_____	_____	TMJ Pain			

Please describe any items marked above: _____

_____

Do you smoke? ___yes ___no If so, how many packs per day? ___1 ___1-2 ___2-3 ___more than 3

Do you drink beer, wine, or other alcoholic beverges? ___yes ___no

If so, how may drinks per week? ___0-3 ___4-10 ___more than 10

Do you use any recreational drugs? ___yes ___no Describe: _____

Are you pregnant? ____yes ____no If so, expected date of delivery: _____

Patient Name: Appt date:
DOB:

FAMILY HISTORY Father: Age, if living: _____ His general health: _____

Or, age at death: _____ Cause of death: _____

Mother: Age, if living: _____ Her general health: _____

Or, age at death: _____ Cause of death: _____

Are there any inherited health conditions or genetic disorders in your family? _____

Please specify: _____

CURRENT MEDICATIONS or attach list DOSE CONDITION

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

_____|_____FOR_____

Please list any vitamins or minerals you take. Specify amount: _____

_____

Are you allergic to any medications, foods, or latex? _____

Date of last physical exam (month & year): ____/____ Conditions treated: _____

_____

Please list any surgery or hospitalizations you have had: _____

_____

List any medical conditions not described above: _____

_____

Has any dental treatment been recommended to you, that you have not yet completed? _____

_____

Have you ever received any kind of TMJ (jaw joint) therapy or surgery? _____

If so, please describe and give dates: _____

Do you clench or grind your teeth during the ___ day or ___ night? _____

Do you often chew ___ fingernails, ___ pencils or pens, or ___ other? _____

Do you regularly see a chiropractor or physical therapist? _____

If so, how often and for what condition(s)? _____

Please list any regular exercise that you do: _____

Have you ___ gained ___ lost weight recently? How much? _____ Over what period of time? _____

Office Use Only: BP: _____ Pulse: _____

Height: _____ Weight: _____

Patient Name: Appt date:

DOB:

NOTICE OF PRIVACY PRACTICES

MN Craniofacial Center, P.C.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

You have the right to read our Privacy Practices Policy, which provides a description of the uses and disclosures we may make of your protected health information.

We reserve the right to update and change our Privacy Practices Policy. If we change the policy, we will issue a revised version containing the changes.

You may obtain a copy of our Privacy Practices Policy, including any revisions, now or at any time by contacting:

Dr. Kim M Ledermann, DDS
Minnesota Craniofacial Center for TMJ and Sleep Treatment
2550 University Avenue West #143N, Saint Paul, MN 55114
Telephone: 651-642-1013 Fax: 651-642-0947
E-mail: info@mncranio.com

I have had full opportunity to read and consider your Privacy Practice Policy. I understand that, by signing this form, I consent to your use and disclosure of my protected health information as necessary to carry out my treatment, perform payment activities associated with my account, and perform health care operations as allowed under federal laws.

Print patient's name: _____

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.

Witness to patient signature: Initials _____

Patient refused to sign form: Initials _____

Revised 6-6-18

Patient Name: Appt date:
DOB:

MINNESOTA
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CENTER FOR TMJ & SLEEP TREATMENT

Practice policies

We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to provide the highest quality care and service to our patients. We take great pride in each staff member's training and capabilities. So that we might all enjoy a smooth working relationship, we ask you to take a few minutes to read over our practice policies:

APPOINTMENTS: We strive to keep our patient's "waiting time" to a minimum, as we recognize that your time is valuable. Therefore, we are able to see our patients on an appointment basis only (with the exception of emergencies). We consider an appointment made to be an agreement and commitment between our office and our patients, and we rely on our fine patients to abide by their agreement. We reserve the right to reschedule your appointment if you arrive more than 15 minutes past your scheduled appointed time.

EMERGENCIES: As emergencies do arise, we ask your patience and understanding in the event of our having to place an emergency patient in front of your appointment slot. We will try to inform you of any changes necessary ahead of time, if at all possible.

FINANCIAL ARRANGEMENTS: During your first visit, our accounts manager will meet with you. Please direct all inquiries about your account to her rather than to the treatment staff. Our accounts manager will be most happy to discuss how our office handles your insurance benefits, if applicable; how your co-payments (if any) are to be taken care of; how any secondary insurance is handled; and how our office financial policy is administered. She will help you arrange the most suitable method of payment for your care. For your convenience, we accept Visa and Master Card.

INSURANCE: As a courtesy to you, we will be happy to submit all insurance claims for services rendered in our office. However, it is up to you to know if your insurance plan requires a referral or a prior authorization, whether insurance deductibles have been met, if there are plan exclusions for TMJ treatment or dental sleep appliances, what percent of coverage you have, whether you are required to make co-payments and what the co-payment will be, and what your plan maximum coverage is per year. Please see the enclosed form to use when calling your insurance company.

OUR COMMITMENT TO YOU: We appreciate having you as a patient in our practice. We will do everything to deliver the highest quality care in a safe, comfortable and caring environment. Please do not hesitate to ask any questions you might have about our services and office policies. In addition, if you are satisfied with our services, please feel free to tell a friend. We welcome new patients and appreciate referrals of your family and friends.

YOUR COMMITMENT TO US: I understand that I am ultimately responsible for my account in this office, regardless of what insurance benefits or other third-party compensation may or may not be applied to my account. I authorize payment of any medical benefits directly to MCC. If my insurance denies coverage for my treatment and an appeal is necessary, I will be expected to pay my balance due within 30 days of receiving the denial. If, after the appeal, my insurance does issue payment to MCC, then MCC will issue me a refund.

I also consent to the release and retrieval of my personal health information by MCC to and from my medical and/or any automobile or other insurance companies, and all third parties involved in my care. I agree to a charge of $50 if I fail or $25 if I cancel a scheduled appointment **without giving MCC a 24-hour notice.**

_____ _____

Patient signature **Date**

Patient Name: Appt date:
DOB: