MAIN LINE SNORING Solutions

Smile Beautifully. Sleep Comfortably. Live a Healthy Life.

New Guest Checklist

Thank you for choosing Main Line Snoring Solutions to help treat your Obstructive Sleep Apnea/Snoring issues. We have designed our new guest checklist to make your first encounter at our office **an exciting and rewarding experience for you, our guest.** In order to expedite your first visit and **help us to determine if your Medical insurance will assist in the treatment costs,** please take a few moments to review the list, gather the needed information and return these forms completely filled out via email or fax immediately. **We need all the necessary information at least 10 days prior to your appointment for all insurance approvals. If we do not receive all the needed information in the time allotted, your appointment will need to be rescheduled.**

- Please email or fax a copy **front and back** of your Medical insurance card(s)
- Please fill out, email or fax the **CPAP Intolerance form** checking off all the reasons why you are not wearing a CPAP, or are not willing to attempt the CPAP.
- Please fill out, email or fax the **New Sleep Assessment form** and the numeric scale at the bottom of the page. Medical insurance usually requires the **total to be a minimum score of an "8"**.
- Please fill out, email or fax all the **New Patient forms**.
- Please bring to the appointment a written list of all **medications** that you are currently taking, along with the **dosages**.
- Please bring a list of **all the physicians you see** (GP, cardiologist, eye doctor, etc), **along with their addresses and phone numbers**, as we like to keep everyone in the loop as to the treatment we provide.
- Last but not least, please bring a **list of any questions or concerns** that will help the doctor personalize your treatment.

If you have any questions, please feel free to call me at the office, or e-mail at: **patti@drgershberg.com** . You can either email, or fax back all the information, if you would prefer to **484-383-3176**. We thank you in advance for your cooperation!

Sincerely,

Patti Staniorski
Practice Coordinator

DR. STEPHEN GERSHBERG • 14 S. Bryn Mawr Avenue - Suite 200A • Bryn Mawr, PA 19010
PH#: 610-527-6704 • FX#: 484-383-3176 • info@drgershberg.com • www.mainlinesnoringsolutions.com

Main Line Snoring Solutions - New Patient Form

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ___

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

The best time to contact me is: ☐ Morning ☐ Mid-Day ☐ Evening on ☐ Home phone ☐ Cell phone ☐ Work phone

Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Address: _____City:_____ State:_____ Zip: _____

Date of Birth (M/D/Y): ___ /___ /_____ Gender: ☐ M ☐ F Social Security Number (SSN): _____

Height: Feet____ Inches____ Weight (lbs): _____ Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Minor

Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____ Phone_____

REFERRED BY: _____

Employer Information

Employer: _____ Phone: (___) _____Fax: (___)_____

Address: _____City_____ State: _____Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ___ /___ /_____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address_____ City_____ State: ____ Zip _____

Phone: (_____)_____Fax: (_____)_____ Email: _____

Please present your insurance card so we can photocopy it.

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___ /___ /____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address_____ City_____ State: ____ Zip _____

Phone :(____)_____ Fax: (_____)_____ Email: _____

Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____

ENT: _____ Phone: _____

SLEEP DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

OTHER MD: _____ Phone: _____

OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ Date:_____

Patient Name:_____

MEDICAL HISTORY

Are you allergic to any medication? If yes, please list below along with a description of the reaction you experienced.

_____

_____

_____

Are there any medications that you are currently taking including over the counter medicines and vitamins? If yes, please list.

_____

_____

_____

Do you have a history of any of the following medical conditions? Please circle.

	Y / N		Y / N		Y / N
Anemia	Y / N	Gastroesophageal Reflux (GERD)	Y / N	Rheumatic fever	Y / N
Arteriosclerosis	Y / N	Hay fever	Y / N	Swollen, stiff or painful joints	Y / N
Asthma	Y / N	Heart disorder	Y / N	Tonsillectomy	Y / N
Autoimmune disorders	Y / N	Heart murmur	Y / N	Injury to face, head, mouth, teeth	Y / N
Bleeding	Y / N	Heart pacemaker	Y / N	Irregular heart beat	Y / N
Chronic sinus issues	Y / N	Hepatitis	Y / N	Low blood pressure	Y / N
Chronic fatigue	Y / N	Hypertension	Y / N	Migraines	Y / N
Congestive heart failure	Y / N	Immune system disorder	Y / N	Muscle spasms or cramps	Y / N
Current pregnancy	Y / N	Insomnia	Y / N	Osteoarthritis	Y / N
Diabetes	Y / N	Jaw joint surgery	Y / N	Poor circulation	Y / N
Difficulty concentrating	Y / N	Memory loss	Y / N	Recent excessive weight gain	Y / N
Dizziness	Y / N	Morning dry mouth	Y / N	Shortness of breath	Y / N
Emphysema	Y / N	Nighttime sweating	Y / N	Thyroid problems	Y / N
Epilepsy	Y / N	Osteoporosis	Y / N	Wisdom teeth extraction	Y / N
Fibromyalgia	Y / N	Prior orthodontic treatment	Y / N		
Frequent sore throats	Y / N				

Patient Name:_____

Have any members of your family (blood relatives) had:

Heart disease	Y ◯ / N ◯
High blood pressure	Y ◯ / N ◯
Diabetes	Y ◯ / N ◯
A sleep disorder	Y ◯ / N ◯

How often do you consume alcohol within 2-3 hours of bedtime?

◯ Nevr ◯ Once a week ◯ Several days a week ◯ Daily ◯ Occasionally

How often do you take sedatives within 2-3 hours of bedtime?

◯ Never ◯ Once a week ◯ Several days a week ◯ Daily ◯ Occasionally

How often do you consume caffeine within 2-3 hours of bedtime?

◯ Never ◯ Once a week ◯ Several days a week ◯ Daily ◯ Occasionally

CPAP INTOLERANCE FORM

I have attempted to use the CPAP machine to manage my Obstructive Sleep Apnea but find it intolerable for the following reasons (please check all that apply):

- ☐ I find the device cumbersome and it interrupts my sleep
- ☐ The machine is noisy and negatively impacts my sleep or my bed partner's sleep
- ☐ I am unable to sleep on my back like the CPAP requires
- ☐ I am unable to tell a noticeable difference in my symptoms of sleep apnea when I wear the machine
- ☐ The pressure on my machine is too high
- ☐ I remove my CPAP unknowingly at night.
- ☐ I feel claustrophobic when I wear the mask.
- ☐ I have been unable to find-a mask that fits properly
- ☐ The mask leaks.
- ☐ The straps or headgear cause me discomfort
- ☐ Latex allergy
- ☐ I refuse to even attempt CPAP.
- ☐ If other please explain:

_____

_____

_____

_____

I have found that I am unable to comply with the CPAP machine as a treatment for my Sleep Apnea. For this reason, I am seeking alternative treatment method for my condition. I realize that the treatments I am consenting to may help my sleep apnea, but may not completely alleviate it (particularly if my sleep apnea is severe). My physician has advised me of alternative therapies that may be used in conjunction with the treatments I am consenting to today.

Patient Name: _____

Date: _____

Patient Signature: _____

Sleep Disorder Assessment

Your physician is requesting that you complete this Sleep Assessment Form.
This form determines the need for you to have a sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your cardiovascular health and well being, but can be effectively treated.

Date _____ **Name**: _____

Phone Number _____ **Physician Name**: _____

Home Address _____

Part 1.

1.	Have you ever been told you have Congestive Heart Failure?	Yes ☐	No ☐
2.	Have you ever been told you have Coronary Artery Disease?	Yes ☐	No ☐
3.	Have you ever had a stroke?	Yes ☐	No ☐
4.	Do you take 3 or more medications for high blood pressure?	Yes ☐	No ☐
5.	Have you ever experienced irregular heart rhythms (atrial fibrillation)	Yes ☐	No ☐
6.	Have you ever been told that you stop breathing at night?	Yes ☐	No ☐
7.	Do you have Diabetes?	Yes ☐	No ☐

Part 2

1.	Have you been told that you snore loudly?	Yes ☐	No ☐
2.	Do you awaken from sleep with chest pain or shortness of breath?	Yes ☐	No ☐
3.	Does your family have a history of premature death in sleep?	Yes ☐	No ☐
4.	Is your neck size larger than 15.5 (female) or 17.0 (male)	Yes ☐	No ☐
5.	Have you ever been diagnosed with Obstructive Sleep Apnea?	Yes ☐	No ☐
6.	Are you currently being treated for sleep apnea?	Yes ☐	No ☐
6a.	If yes, are you using your apparatus every night?	Yes ☐	No ☐

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale: 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more	◯0	◯1	◯2	◯3
2. Sitting and talking to someone.....	◯0	◯1	◯2	◯3
3. Sitting and reading.....	◯0	◯1	◯2	◯3
4. Watching TV.....	◯0	◯1	◯2	◯3
5. Sitting inactive in a public place.....	◯0	◯1	◯2	◯3
6. Lying down to rest in the afternoon.....	◯0	◯1	◯2	◯3
7. Sitting quietly after lunch without alcohol.....	◯0	◯1	◯2	◯3
8. In a car, while stopped for a few minutes in traffic...	◯0	◯1	◯2	◯3

Total score _____

Physician Signature: _____ **Date:** _____

CHIEF COMPLAINT

Name: _____ DOB: _____

Current date: _____

Please answer the questions below:

What are the chief complaints for which you are seeking treatment
Number the complaints with #1 being the most important.

_____ Frequent heavy snoring which affects the sleep of others
_____ Daytime sleepiness
_____ I have been told that I stop breathing
_____ I have trouble falling asleep
_____ Gasping when I wake up
_____ Nighttime choking spells
_____ I feel unrefreshed in the morning
_____ My throat is hoarse in the morning
_____ I frequently have morning headaches
_____ I have swelling in my ankles and/or feet
_____ I grind my teeth
_____ My jaw clicks
_____ Other _____

Stephen J. Gershberg, D.M.D.

14 S. Bryn Mawr Ave., Ste #200
Bryn Mawr, PA 19010
610-527-6700
610-527-6704 (fax)

Records Request

I,_____, authorize _____ to release my records, films/xrays, as soon as possible, to Dr. Gershberg's office at the address on this letterhead. Thank you for your prompt attention.

Signed_____ Dated_____

Witness_____ Dated_____

MLSS Office Financial Policy

We are committed to providing you with the best possible care, while making your treatment affordable to all of our patients. In order to achieve these goals and to keep the rising costs of medicine to a minimum, we ask for your assistance and understanding of our policy.

1. **Payment for services is due at the time services are rendered, by you, the patient or guardian, unless prior payment arrangements have been made and approved by our financial coordinator in advance of the appointment.** We offer the following:

    - **Cash or Check**
    - **Visa, MasterCard, or Discover**
    - **Debit bank cards**
    - **Care Credit Financing (www.carecredit.com)**

2. **If you have medical insurance, we will be happy to verify and process your insurance claims.** While the filing of claim forms is a courtesy that we extend to our patients, **all charges are your responsibility at the time of treatment. And if payment from the insurance company should be sent to you, it is your responsibility to forward the payment and the Explanation of Benefits (EOB) to our office. If not, then the payment becomes your responsibility.**

3. **Six (6) months after insert of oral device, there is an office visit charge of $50 for each and every visit thereafter, not billable to Medicare or Private Insurance, and payable by you, the patient.**

4. **An addition, the first A.M. bite aligner is provided to you at no charge. Any needed replacements due to loss of aligner or excess wear noted on the aligner, will result in a charge of $45 for replacement, also not billable to Medicare or Private Insurance and payable by you, the patient.**

5. **Returned checks and balances over 30 days are subject to any resulting bank fees that we incur and interest charges of 1.5% per month.**

If you have any questions regarding this policy or your insurance, please do not hesitate to ask.

Patient/Guardian Signature:_____ date:_____

Witness Signature:_____ date:_____

Notice of Privacy Practices
Stephen J. Gershberg, D.M.D., P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse To Sign This Acknowledgement****

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

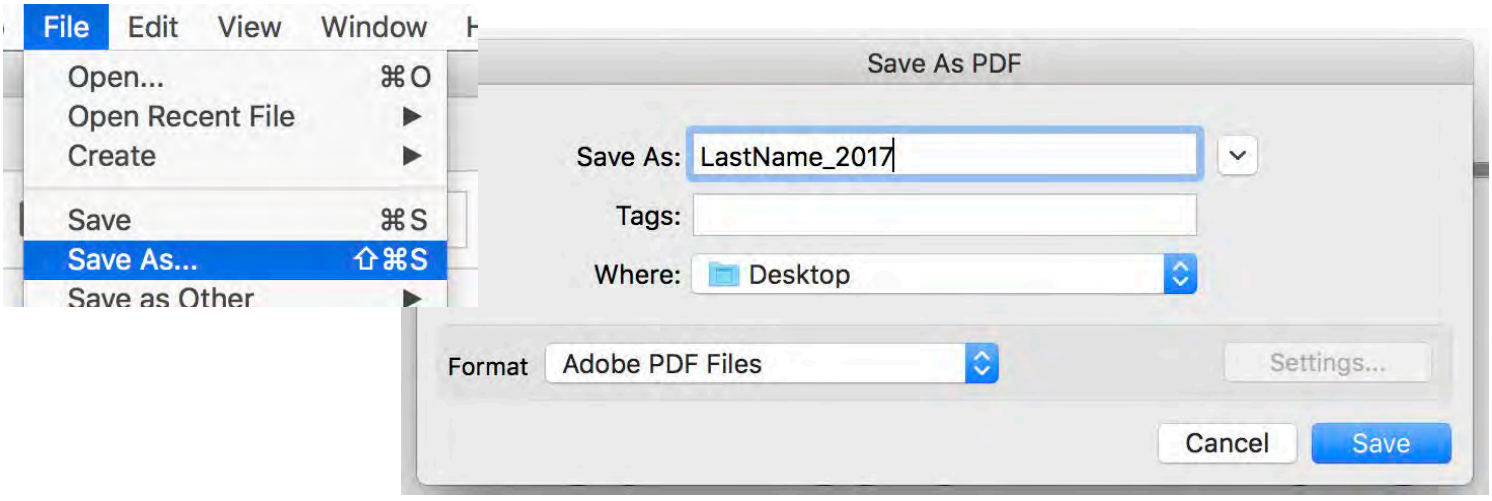
_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (please circle one)

1. Individual refused to sign
2. Communications barrier prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining the acknowledgement
4. Other (Please Specify)_____
_____.

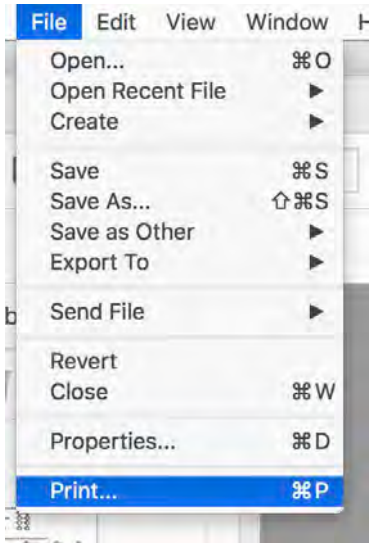
SUBMISSION METHODS

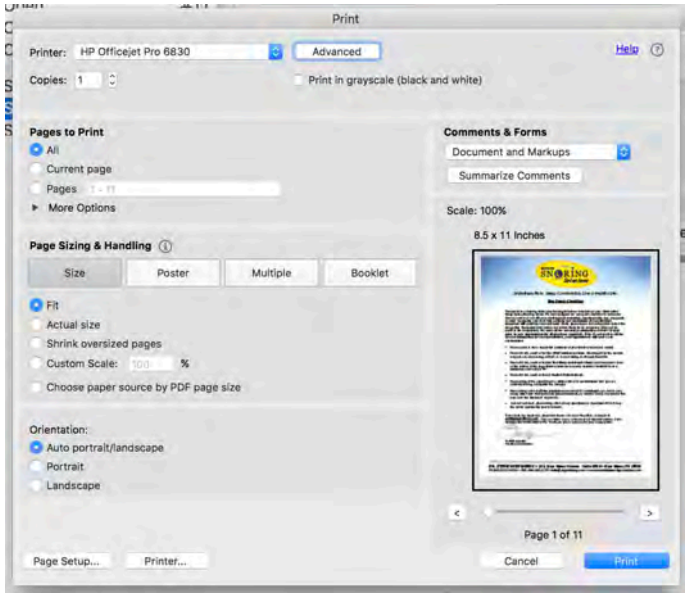


METHOD 1: SAVE & SEND

Go to **File** > **Save As** and save your form (include last name and the year). Save the PDF onto your computer. Then simply open your email, attach the PDF and send the email to:

info@drgershberg.com





METHOD 2: PRINT & SEND

If you prefer to PRINT and MAIL then go to **File** > **Print** and then mail them to us at the address below so that we have them 10 days before your visit.

14 S. Bryn Mawr Avenue Suite 200A
Bryn Mawr, PA 19010