TRUEDENTAL

7003 Shallowford Rd., Suite 101
Chattanooga, TN 37421
Phone 423-899-9755

Dear Patient,

Your sleep physician has referred you to my office. Your referring physician feels you might benefit from an intra-oral appliance which is designed to improve your breathing during sleep by advancing your lower jaw or holding your tongue forward. This movement helps to open the airway space which can reduce snoring and sleep apnea in many cases. We cannot guarantee that this device will be successful for all patients because there are many factors involved in sleep apnea.

Patients who have been diagnosed as having sleep apnea should have routine visits to their physician or sleep disorders center. Moderate or severe obstructive sleep apnea is a potentially life threatening disease, and periodic monitoring of the disease is important. The intra-oral sleep apnea appliance does not cure snoring or sleep apnea, but is designed to reduce snoring and apneic episodes while it is being worn. If your physician has suggested a change in sleeping position or weight loss these actions are important and are to be accomplished IN ADDITION to using the intraoral device.

Prior to the fabrication of any intra-oral device, you must have a consultation appointment with us to evaluate your oral condition as well as to discuss possible choices of treatment. This will be a limited exam if you are currently receiving care by another general dentist (last two years) and unaware of needing treatment. If you are NOT under the care of a general dentist, or aware of loose, broken or hurting teeth, it will be necessary to have us perform a comprehensive oral exam including new radiographic images to rule out periodontal disease and tooth decay.

If you require new fillings, crowns (caps), implant placement, or periodontal therapy, these procedures should be completed BEFORE the appliance is made. Any change in your dentition may require construction of a new device. If you do not have a general dentist, we can perform all the services you may require.

Normally one to two appointments are required to fabricate the appliance, followed by appointments to adjust the fit of the device and evaluate its degree of effectiveness. The fit, wear and comfort of the appliance will be evaluated as the patient deems necessary.

When you come to your evaluation appointment please bring the following items:

1. Recent radiographic images (x-rays) from your dentist's office (bitewings or full mouth series)
2. A copy of your most recent sleep study report
3. Your sleep physicians referral letter or prescription *indicating they recommend an intra-oral sleep appliance for you* (we can provide this to you)
3. Any authorization forms your medical insurer may require for coverage
4. If you wear a mouthpiece of any sort (orthodontic retainer, night guard, etc.) please bring it with you to your appointment

Most insurance companies will pay something for oral appliances to treat obstructive sleep apnea, but may be very strict in their definition of 'sleep apnea'. You may wish to check with your insurer prior to your appointment. The billing code for a custom fabricated oral device is E0486.

Please read all enclosures, complete **AND SIGN** the enclosed forms and bring them with you to your appointment. Any questions you may have can be answered during the appointments necessary to fabricate your oral appliance.

I look forward to taking care of you!
Dr. Joel Davis DDS

Affidavit of Intolerance to CPAP

(Continuous Positive Air Pressure)

- ❑ I have attempted to use nasal CPAP to manage my sleep disorder breathing (obstructive sleep apnea) and find it intolerable to use on a regular basis due to the following reason(s):
- ❑ CPAP is not effective in controlling my symptoms.
- ❑ I am unable to sleep with the CPAP equipment in place.
- ❑ The noise from the device disturbs my sleep or my bed partner's sleep.
- ❑ I cannot find a comfortable mask.
- ❑ The mask leaks.
- ❑ I develop sinus/throat/ear/lung infections.
- ❑ I am allergic to the materials in the mask and head straps.
- ❑ Claustrophobia
- ❑ I unconsciously remove the CPAP apparatus at night.
- ❑ The pressure of the mask and straps causes tissue breakdown.
- ❑ My job and/or lifestyle prevents this form of therapy (e.g. Active Army/National Guard duty)
- ❑ Prior throat surgery made CPAP intolerable.

Other_____

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of OSA, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

Signed: _____

Date: _____

Current Conditions/Review of Systems

Do you currently have any of the following? Boxes left blank indicate a "no"answer.

General:

- ❑ Tire easily
- ❑ Marked weight change
- ❑ Night sweats
- ❑ Persistent fever
- ❑ Sensitivity to heat or cold

Skin:

- ❑ Rashes
- ❑ Changes in hair or nails

Eyes:

- ❑ Change in vision, double vision

Head:

- ❑ Headache, dizziness, trauma

Ears:

- ❑ Change in hearing
- ❑ Ringing in ears
- ❑ Discharge

Nose:

- ❑ Change of smell
- ❑ Deviated septum
- ❑ Rhinits (runny nose)
- ❑ Bleeding
- ❑ Sinus infections

Mouth:

- ❑ Sore gums or tongue
- ❑ Lumps or ulcers

Throat:

- ❑ Soreness
- ❑ Hoarseness

Neck:

- ❑ Swelling
- ❑ Muscle Pain
- ❑ Stiffness
- ❑ Thyroid/goiter

Heart and Lungs:

- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Yellow or green sputum
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Chest Pain/Tightness
- ❑ Difficulty breathing lying down
- ❑ Swelling of ankles
- ❑ High blood pressure
- ❑ Pneumonia
- ❑ Palpitations

Digestive:

- ❑ Change in appetite
- ❑ Difficulty swallowing
- ❑ Heartburn
- ❑ Abdominal Pain
- ❑ Jaundice
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Bloody stool
- ❑ Change in stool
- ❑ Diarrhea

Hematologic:

- ❑ Anemia
- ❑ Bruising easily
- ❑ Bleeding disorders
- ❑ Transfusion

Urologic:

- ❑ Kidney infections
- ❑ Difficulty urinating
- ❑ Increased frequency of urination
- ❑ Kidney stones
- ❑ Bladder infection
- ❑ Blood in Urine

Musculoskeletal:

- ❑ Muscle cramps
- ❑ Gout
- ❑ Pain or swelling in joints

Nervous System:

- ❑ Dizziness
- ❑ Confusion
- ❑ Memory Loss
- ❑ Seizures
- ❑ Depression/mental illness

Questionnaire For Snoring/Sleep Apnea

Name_____Age_____Sex_____Date_____

The Epworth Sleepiness Scale

Circle the number that represents your chance of Dozing or Sleeping

Situation:	Never	Slight	Moderate	High
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. movie theater or meeting)	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 when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In the car, while stopped for a few minutes in traffic	0	1	2	3
Totals:				

Total ☐

Behavior During Sleep

Use the following scale to choose the most appropriate number for each.

Situation:

0 = never during a usual night
1 = less than once a week
2 = once to about half the nights/week
3 = half the nights to almost always
4 = almost always or every night
? = don't know or haven't been told

During your usual sleep, you have noticed or have been told you do the following:

Please write your answer in the blank (0-4, ?)

Snore loudly _____
Stop breathing _____
Choke, struggle for breath _____
Toss and turn frequently _____
Wake up with a headache _____
Usual number of hours of sleep/night _____
Number of times you rise to use the toilet _____

Total ☐

Patient History

Family History

1. Have any members of your family (blood kin) had:

Heart Disease	▢ Yes	▢ No
High Blood Pressure	▢ Yes	▢ No
Diabetes	▢ Yes	▢ No

2. Have any immediate family members been diagnosed or treated for a sleep disorder? ▢ Yes ▢ No

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?
▢ Never ▢ Once a week ▢ Several days a week ▢ Daily ▢ Occasionally

Sedative consumption: How often do you take sedative within 2-3 hours of bedtime?
▢ Never ▢ Once a week ▢ Several days a week ▢ Daily ▢ Occasionally

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?
▢ Never ▢ Once a week ▢ Several days a week ▢ Daily ▢ Occasionally

Do you smoke?
If yes, enter the number of packs per day (or other description of quantity):_____

Do you use chewing tobacco? ▢ Yes ▢ No

Height: _____feet_____inches

Weight:_____pounds

I authorize the release of a full report of examination finding diagnosis, treatment programs, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature:_____Date:_____

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea

Physician:_____Telephone:_____

Office Address:_____

Patient Name:_____

Patient Address:_____

Patient Telephone:_____

Prescription to be filled by:
Joel Davis DDS
NPI: 1831530914
Office Phone: 423-899-9755
Office Fax: 423-499-0005
7003 Shallowford Rd. Ste. 101
Chattanooga, TN 37421

The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have

- ❑ Obstructive sleep apnea or Severity_____
- ❑ Simple Snoring

This patient is:

- ❑ Intolerant of CPAP therapy
- ❑ Is not a candidate for CPAP therapy

Explanation (if necessary):_____

The patient is being sent for OA therapy with:

- ❑ The appliance chosen by the dentist and the patient as most suitable
- ❑ A _____ appliance (specific name)
- ❑

Signature of referring physician: _____Date:_____

Obstructive Sleep Apnea is a medical condition that tends to become more severe with time, and requires periodic re-evaluation by a qualified physician. Oral Appliance Therapy is less effective in controlling this disease than CPAP, and patients referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea. Copies of Sleep Studies with full report are required by the dentist for appropriate care and to obtain medical insurance coverage.

Original Prescription *MUST* be mailed or delivered to the treating dentist.

Informed Consent

For the Treatment of Sleep Disordered Breathing 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 a person's 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) for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. 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.

A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, 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. 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 bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, continuous positive airway pressure (CPAP) and various surgeries. The risks and benefits of these alternative treatments should be discussed with your healthcare provider. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you.

It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, and consent to performance of oral appliance therapy, please sign and date this form below. You will receive a copy.

Signature: _____Date:_____

Printed Name:_____