



**CONFIDENTIAL**

Welcome to Westlake Family Dentistry

**Patient Registration Information**

Please fill out new patient forms in ink and don't hesitate to ask if you have any questions!

Name: \_\_\_\_\_  
First Middle Last Preferred Name Date of birth Age

Address: \_\_\_\_\_  
City State Zip code Social Security #

Home Phone: \_\_\_\_\_  Cell: \_\_\_\_\_  Work: \_\_\_\_\_

\*\*Mark Preferred Number

Single  Married  Divorced  Minor Place of Employment: \_\_\_\_\_

Referred by:  Friend/Family [Name] \_\_\_\_\_  Dr. \_\_\_\_\_

Direct Mail  Walk-in  Insurance \_\_\_\_\_  Internet \_\_\_\_\_

Email Address: \_\_\_\_\_

**Responsible Party Information (If under age 18 only)**

Name: \_\_\_\_\_  
First Middle Last Date of Birth

Address: \_\_\_\_\_  
City State Zip code Social Security #

Home Phone: \_\_\_\_\_  Cell: \_\_\_\_\_  Work: \_\_\_\_\_

\*\*Mark Preferred Number

Place of Employment: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Medical Insurance Information**

Name of Insured: \_\_\_\_\_  
First Middle Last Date of birth

Address of Insured: \_\_\_\_\_  
City State Zip code Social Security #

Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_ Member ID: \_\_\_\_\_

**Emergency Contact Information (Outside of immediate household)**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Financial Responsibility**

We will gladly check your insurance benefits, give you an estimate for any portions that may be due by you and bill your insurance at the time of treatment.

**Payment for your estimated portion is due at the time services are rendered.** For your convenience we accept the following methods of payment: **Cash, Checks, Visa, MasterCard, Discover, HSA/FSA cards & CareCredit.**

**\*\*Balances over 30 days may incur a 1.5% monthly finance charge.**

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed and/or canceled appointments may result in a \$50-\$100 fee. I authorize Westlake Family Dentistry to bill my insurance company as well as release any information needed to do so and assign benefits to Bradley E. Sievert, DMD, PC.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Patient Dental History**

Name: \_\_\_\_\_

Westlake Family Dentistry

What is your primary reason for your visit today? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ Name of current dentist: \_\_\_\_\_

Have your previous dental experiences been favorable? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

**Have you experienced any of the following:**

	Yes	No		Yes	No
Sensitivity to hot or cold.....	<input type="checkbox"/>	<input type="checkbox"/>	Root canal treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets or sour.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to pressure/biting.....	<input type="checkbox"/>	<input type="checkbox"/>	Habitual grinding or clenching of teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums while brushing/flossing.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently bite cheeks/lips.....	<input type="checkbox"/>	<input type="checkbox"/>	Clicking or popping of jaw.....	<input type="checkbox"/>	<input type="checkbox"/>
Sores or lumps in or around your mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ear or side of face.....	<input type="checkbox"/>	<input type="checkbox"/>
Gum recession.....	<input type="checkbox"/>	<input type="checkbox"/>	Crooked teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal (gum) treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Does food catch between your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Cracked or broken teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficult extractions.....	<input type="checkbox"/>	<input type="checkbox"/>	Discolored teeth.....	<input type="checkbox"/>	<input type="checkbox"/>

**Medical History**

This information will help us in preventing serious medical complications. Please let us know if there is anything not listed, that you feel we should know about, in regards to your medical/dental health.

Name of Physician: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Are you under medical treatment now? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Have you been hospitalized or had a serious illness in the last 3 years? \_\_\_\_\_ Explain: \_\_\_\_\_

Do you smoke or use smokeless tobacco? \_\_\_\_\_ If yes, how often? \_\_\_\_\_ How many years? \_\_\_\_\_

**Please list any medications, including non-prescription medicine:**

**Have you had, at any time, any of the following:**

_____			Aids/HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Angina/Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Artificial joint/Implant...	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure..	<input type="checkbox"/>	<input type="checkbox"/>
_____			Asthma/resp. problems...	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Bleeding problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergies or reactions to:</b>	<b>Y</b>	<b>N</b>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea.....	<input type="checkbox"/>	<input type="checkbox"/>
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach issues/ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____			Glaucoma/Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Use of CPAP.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Women:</b> Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

**I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to my medical/dental health.**

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Sleep Questionnaire

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Westlake Family Dentistry

**Please answer the following questions to the best of your knowledge.**

	<b>Y</b>	<b>N</b>	<b>Notes</b>
Has anyone ever told you that you snore? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you feel tired or easily fatigued during the day? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wake up with a dry mouth or sore throat? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you feel you have restless or fitful sleep? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you experience choking, snorting or gasping during sleep? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you awaken in the morning still feeling tired or groggy? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you suffer from getting up frequently at night? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you experience forgetfulness and difficulty concentrating? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you fall asleep sitting, reading or watching TV? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you fall asleep while driving? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you get morning headaches or frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
How many each week? _____ Each month? _____			

**Have you had, at any time, any of the following?**

High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Gain.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular Heart Beat.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety/Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Epworth Sleepiness Scale**

Name: \_\_\_\_\_ Sex:  Male  Female

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How likely are you to doze off or fall asleep in the situations described below, 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

<b>Situation</b>	<b>Chance of dozing</b>
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 lunch, without alcohol .....	_____
In a car, while stopped for a few minutes in traffic .....	_____
Total .....	_____

Score:  
 0-10 Normal range  
 10-12 Borderline  
 12-24 Abnormal

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Sleep Consultation

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Westlake Family Dentistry

Patient Name: \_\_\_\_\_

## WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints by severity with #1 being the most severe, #2 the second most severe and so on.

- |   |   |
|---|---|
| <input type="checkbox"/> CPAP intolerance   | <input type="checkbox"/> Significant daytime drowsiness |
| <input type="checkbox"/> Difficulty falling asleep                                | <input type="checkbox"/> Sleepiness while driving       |
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Witnessed apneic events        |
| <input type="checkbox"/> Frequent heavy snoring                                   | <input type="checkbox"/> Morning headaches              |
| <input type="checkbox"/> Frequent heavy snoring which affects the sleep of others | <input type="checkbox"/> Leg movements/ Restless legs   |
| <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Teeth Grinding                 |
| <input type="checkbox"/> Gasping when waking up                                   | <input type="checkbox"/> Limited mouth opening          |
| <input type="checkbox"/> Nighttime choking spells                                 |   |

Other: \_\_\_\_\_

### CPAP Intolerance (Continuous Positive Airway Pressure Device)

The reason why you have not tried a CPAP or If you have attempted treatment with a CPAP device, but could not tolerate it please fill in the section below.

- |  |   |
|--|---|
| <input type="checkbox"/> Mask leaks                                | <input type="checkbox"/> Pressure on the upper lip causing tooth related problems |
| <input type="checkbox"/> Inability to get the mask to fit properly | <input type="checkbox"/> Latex allergy  |
| <input type="checkbox"/> Discomfort from headgear                  | <input type="checkbox"/> Noise disturbing sleep and/or bed partner's sleep        |
| <input type="checkbox"/> Disturbed or interrupted sleep            | <input type="checkbox"/> An unconscious need to remove the CPAP                   |
| <input type="checkbox"/> Claustrophobic associations               | <input type="checkbox"/> CPAP restricts movements during sleep                    |
| <input type="checkbox"/> CPAP does not seem to be effective        | <input type="checkbox"/> Cumbersome   |

Other: \_\_\_\_\_

### Other Therapy Attempts

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> CPAP        | <input type="checkbox"/> Pillar procedure  | <input type="checkbox"/> Uvuloplasty surgery |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Smoking cessation | <input type="checkbox"/> Uvulectomy surgery  |
| <input type="checkbox"/> Other _____ |  |  |

### History of Treatment

Practitioners Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Treatment: \_\_\_\_\_ Approximate Date: \_\_\_\_\_

Practitioners Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Treatment: \_\_\_\_\_ Approximate Date: \_\_\_\_\_

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician, as well as the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage. I certify that my medical history information is complete and accurate to the best of my knowledge.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Westlake Family Dentistry

**Financial Policy & Insurance**

We are committed to providing you with the best possible care. If you have dental/medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment protocol.

**Payment for treatment is due at the time services are rendered**, unless payment arrangements have been approved in advance by our financial coordinator. We accept cash, checks, Visa, MasterCard, Discover, HSA/FSA cards and CareCredit. As a patient, you are fully responsible for all fees for services rendered. As a courtesy we file your insurance claims for you and accept payments directly from your insurance carrier in order to help you simplify the insurance process. If your insurance does not pay any portion of your bill you will be billed accordingly and are fully responsible for any outstanding balance. If you have secondary insurance we will be happy to bill them for you as well. **We offer a 5% discount on any amounts over \$500, when paying by cash or check only, at the time of service.**

**When using your dental/medical insurance benefits, please understand that:**

1. Your insurance is a contract between you, your employer and the insurance company.
2. Some insurance policies restrict payment for some services. They use restricted fee schedules (called "UCR") and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *NOT* our fees or recommended treatment. Some insurance companies arbitrarily select certain services they will not cover.

**As dental care providers, we must emphasize that our relationship is with you, not your insurance company.** While the filing of insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**Returned checks are subject to a \$30 charge and balances older than 30 days may be subject to interest charges of 1.5% per month or 18% per annum.**

**We require 48 business hours' notice for cancelations or rescheduling. Appointments canceled or rescheduled without 48 business hours' notice, and missed appointments may incur up to a \$100 fee.**

You will be given a printed treatment plan any time treatment is recommended, and we will gladly discuss your proposed treatment and answer any questions relating to your insurance benefits, before treatment is rendered.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. We are here to help.

**I understand that Westlake Family Dentistry will make every effort to give accurate insurance benefit estimates for my treatment, however, I am responsible for any portion not covered by my insurance company after claims have processed, as well as my estimated portion due at the time of service.**

**I understand that I am responsible for payment in full, at the time of treatment, if dental insurance is not applicable to my situation, unless other arrangements have been made in advance.**

**I have read, understand and agree to abide by the above financial policy.**

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Acknowledgement of Receipt of  
Privacy Policy Notice**

I, \_\_\_\_\_, have read, received and/or have been offered a copy of Westlake Family Dentistry’s PRIVACY POLICY NOTICE and consent to the use of my protected health information to carry out treatment, payment activities, and healthcare operations as explained.

I understand that my information will not be disclosed in any way not outlined in the above mentioned policy, unless I have given written consent, which may be revoked at any time by me, in writing. **This includes, but is not limited to my spouse, mother, father and/or siblings.** If under age 18, information will be shared with parents and/or legal guardians.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Signature or Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**Patients age 18 and older: please complete the following and mark what information may be shared. If there is no one you consent to share information with, please leave section blank and do not sign.**

**I give consent to share my information with the following parties, should they inquire:**

- Spouse: \_\_\_\_\_ Personal: YES / NO Financial: YES / NO
- Mother: \_\_\_\_\_ Personal: YES / NO Financial: YES / NO
- Father: \_\_\_\_\_ Personal: YES / NO Financial: YES / NO
- Other: \_\_\_\_\_ Personal: YES / NO Financial: YES / NO

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our PRIVACY POLICY NOTICE, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prevented obtaining this acknowledgement
- OTHER: \_\_\_\_\_



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Westlake Family Dentistry

**Informed Patient Consent**

**Patient Name :** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Welcome! We would like to give you a little more information about ourselves, and what to expect during our sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

**CONFIDENTIALITY AND PRIVACY NOTICE:**

Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_





**Dr. Mark Gabr**  
**Dr. Muhammad Najjar**  
**Dr. Roukan Jazayerli**  
**Dr. Ravi Shergill**  
**Dr. Bradley Sievert**  
**John Glenn PA-C**

21260 S. Springwater Rd | Estacada, OR 97023

Phone: 800-279-3104 | Fax: 949-798-6979 | dentalinfo@dedicatedsleep.net | dedicatedsleep.net

## **Medical Records Release Form**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Dedicated Sleep 21260 S. Springwater Rd Estacada, OR 97023

Oregon Sleep Specialists 5331 SW Macadam Ave Portland, OR 97239

**Patient Signature:** \_\_\_\_\_

**Date signed:** \_\_\_\_\_