DR. KATHRYN MOORE
DR. SARAH TROTTER

Dear Patient

Together with the advice and prescription of your neurologist/sleep medicine physician you have decided to investigate oral appliance therapy for the management of your sleep apnea.

Our Team

Dr. Moore is a member of the American Academy of Dental Sleep Medicine (AADSM), the only non-profit professional association dedicated exclusively to the practice of dental sleep medicine. For over a decade we have been helping treat snoring and obstructive sleep apnea with oral appliance therapy, an effective treatment that may be covered by your insurance plan. AADSM membership provides Dr Moore with access to educational resources and practice management tools that help her better serve her patients by providing the highest quality of care in the treatment of snoring and obstructive sleep apnea.

Information Websites

There are several informative websites with information on sleep apnea, oral appliances and specifically the three most commonly used oral appliances in our practice. You may find it helpful to review these prior to your visit at our office.

The American Society of Dental Sleep Medicine:www.aadsm.org
Klearway appliance:www.klearway.com
Somnodent appliance:www.somnomed.com
Resmed Narval appliance:www.resmed.com
Dr. Kathryn Moorewww.drkathrynmoore.com

Information Documents Included in this Package

Sleep Disordered Breathing
Oral Appliance Therapy for the Treatment of Sleep- Disordered Breathing

Forms to Print, Complete and Bring to Your First Visit

Medical History
Dental History
Epworth Sleepiness Scale

Your First Visit

We will complete a review of your medical and dental history, a clinical examination of your oral soft and hard tissues, examination of your temporomandibular joints and a panoramic radiograph. This will allow us to review your dental health and ability of your teeth and jaws to support the appliance. Any questions regarding the appliances and treatment will be answered.

2032 Dentistry
201-A George Street North,
Peterborough, ON K9J 3G7
705 743-5924 Fax: 705 743-5080
www.2032Dentistry.com
info@2032Dentistry.com

DR. KATHRYN MOORE
DR. SARAH TROTTER

Consultation Fee

Often, the initial fee of $198 for the examination, photographs and panoramic radiograph are covered benefits under your dental insurance plan, the appliance fabrication and maintenance fee is covered by some extended medical benefits and we will work with you to provide documentation to apply for these.

We look forward to working with you and your sleep physician in providing effective treatment of your sleep apnea.

Please feel free to contact the office at any time with questions.

Sincerely,

Kathryn Moore B.Sc., D.D.S.

2032 Dentistry
201-A George Street North,
Peterborough, ON K9J 3G7
705 743-5924 Fax: 705 743-5080

www.2032Dentistry.com
info@2032Dentistry.com

AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL RECORDS AND RADIOGRAPHS

Current/Previous Dentist:

This note authorizes the transfer of my (and listed family members) dental/medical records to the office of:

2032 Dentistry
Dr. Kathryn Moore
Dr. Sarah Trotter
Email: info@2032Dentistry.com
Fax: 705 743-5680

Patients Names	Signatures (ages 16 and over)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Address:

Street: _____ City: _____

Postal Code: _____ Province: _____

Phone Number:_____ Email: _____
_____

Dr. Kathryn Moore
Dr. Sarah Trotter

PERSONAL INFORMATION

PATIENT'SLASTNAME	FIRST	MIDDLE	DATE OF BIRTH / / M D Y	SEX M F
HOME PHONE	WORK PHONE	MOBILE		
PATIENT'S MAILING ADDRESS	CITY		PROV.	POSTAL CODE
E-MAILADDRESS				
Preferred Contact Method (please check) HomePhone WorkPhone MobilePhone Mobile Text Email				
PERSON RESPONSIBLE FOR ACCOUNT		RELATIONSHIP	DATE OF BIRTH / / M D Y	
PATIENT'S GUARDIAN IF UNDER 18		PATIENT/GUARDIAN'S EMPLOYER	WORK PHONE	
PATIENT OR GUARDIAN'S SPOUSE		EMPLOYER	WORK PHONE	

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)		
NAME	PHONE	ALTERNATE PHONE

IF THIS IS YOUR FIRST VISIT, HOW DID YOU HEAR ABOUT OUR OFFICE?	
Referred by another person:	Other:

DO YOU HAVE DENTAL INSURANCE COVERAGE?If yes, Please provide our reception staff with your benefits information		
Primary Coverage Insurer:	Secondary Coverage Insurer	Tertiary Coverage Insurer

PAYMENT POLICY

Dental plans in the marketplace today are too numerous and varied to allow us to know the details of all of them. Your particular dental plan may or may not cover the full extent of the costs you incur for your dental treatment. This can occur because the fees in our office are based on factors which may not have been considered by your insurance carrier. Furthermore, there may be certain procedures performed which are not covered through your dental plan. These factors are beyond ourcontrol.

PLEASE REVIEW YOUR DENTAL PLAN CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS AND LIMITATIONS OF YOUR PLAN

Payment for dental services is expected when treatment is rendered. You will be informed of your amount at the time treatment is completed so that you may make payment at that visit. A 2% service charge will be applied to all account balances outstanding for more than 30days.

I am financially responsible for any balances due and authorize the dentists to release any information for any claim

I certify that I have read or had read to me the contents of this form, filled in completely and accurately to the best of my knowledge and do realize the risks and limitations involved.

Patient/GuardianSignature **Date** _____

2032 Dentistry – *Dentistry for Life*
201-A George Street North,
Peterborough, ON K9J 3G7
705 743-5924 : Fax: 705 743-5080
www.2032Dentistry.com
info@2032Dentistry.com

Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required bylaw.

We collect information from our patients such as names,home addresses, home and/or work telephone numbers, and e-mailaddresses(collectivelyreferredtoas"ContactInformation").

Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients and/or legal guardians or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third---party benefit providers, insurance companies and government agencies.
- To send reminders to patients concerning the need for further dental examinationor treatment.
- To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services from whoever has been written as financially responsible for the account.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dentaltreatment.

Patients' Medical Information is disclosed:

- To all third-party benefit providers, insurance companies and government agencies where a claim is being submitted for reimbursement or payment of all or part of the cost of dentaltreatment.
- To other dentists and dental specialists, where further information and/or discussion is required.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist of dental specialist for treatment.
- To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- Where we are seeking and/or providing information to the following: laboratories, radiology centres, hospitals, etc.
- To include the following when necessary, such as: videos, pictures, slides, etc., for educational purposes.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access, as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure the prospective purchaser safeguards all personal information.

Dentists are regulated by the Royal College of Dental Surgeons of Ontario which may inspect our records and interview our staff as part of its regulatory activities in the public interests.

I consent to the collection, use and disclosure of my personal information as set outabove.

Patient/GuardianSignature_____ **Date**_____

2032 Dentistry.

DENTAL HISTORY

Dr. Kathryn Moore
Dr. Sarah Trotter

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years _____
Date of most recent dental exam ____yyyy_/_____mmm_/_____dd_____ Date of most recent x-rays ____yyyy_/_____mmm_/_____dd_____
Date of most recent treatment (other than a cleaning) ____yyyy_/_____mmm_/_____dd_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Dr. Kathryn Moore
Dr. Sarah Trotter

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver,_____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea)_____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements_____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

ORAL APPLIANCE THERAPY
FOR THE TREATMENT OF SLEEP-DISORDERED BREATHING

Oral appliance therapy for snoring/obstructive sleep apnea assists breathing during sleep by keeping the tongue and jaw in a forward position.

Frequently Asked Questions

1. ***What is an Oral Appliance?***

   It is a removable device worn in the mouth during sleep that helps control sleep apnea and snoring, thus improving sleep quality. The appliance gently positions the lower jaw and tongue slightly forward. This opens space in the back of the throat and reduces tissue obstruction to help keep your airway open and clear during sleep.

2. ***What are the benefits of Oral Appliance Therapy?***

   Sleep Apnea may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This can result in problems such as daytime sleepiness, driving and work related accidents, irregular heartbeats, high blood pressure, heart disease, stroke, obesity, and memory and learning problems. By wearing an oral appliance during sleep, your body may be able to maintain higher blood oxygen levels and lessen the severity of problems associated with sleep-disordered breathing.

3. ***What are the risks of wearing an Oral Appliance during sleep?***

   Short-term side effects may include excessive salivation, difficulty swallowing with the appliance in place, sore jaws, sore teeth, jaw joint pain, dry mouth and short term bite changes. Most of these side effects are minor and resolve quickly on their own.

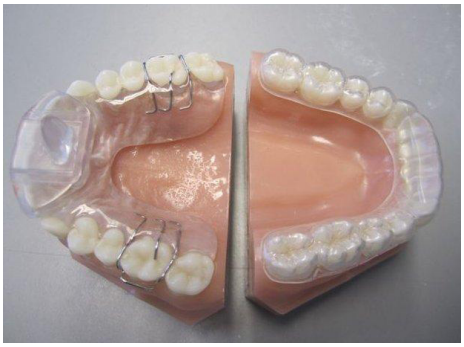
   Long-term complications may include permanent and significant bite changes as a result of wearing an Oral Sleep Appliance. Follow-up visits with the provider of your oral appliance are needed to ensure proper fit and effectiveness.

4. ***What are the alternatives to Oral Appliance Therapy?***

   Other accepted treatments for sleep-disordered breathing may include behavioral modifications, continuous positive airway pressure (CPAP) and various surgeries.

5. ***What are the post-treatment considerations?***

   Follow-up visits with your provider are mandatory to ensure a proper fit and to examine your mouth to ensure a healthy condition. Alert your provider if you experience any changes. After fitting your Sleep Appliance, a sleep study is necessary to objectively ensure effective treatment.

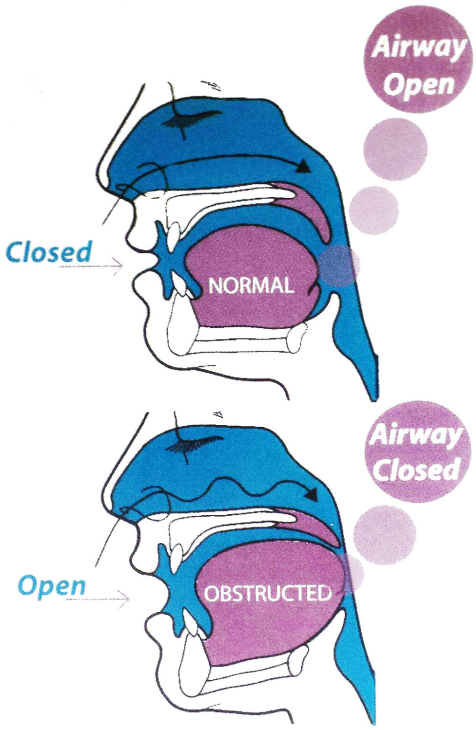


Various sleep appliances

SLEEP-DISORDERED BREATHING

A sleep disorder prevents you from getting healthy and restful sleep. Many sleep disorders are undetected because a person can slowly become accustomed to the symptoms. For example, waking up tired or falling asleep reading a book might be signs of a sleep disorder.

Frequently Asked Questions



1. ***What is Sleep-Disordered Breathing?***
   Sleep-disordered breathing (also known as sleep apnea or upper airway resistance syndrome) is a serious sleep disorder that impairs your breathing while asleep. Anyone can have sleep-disordered breathing, even children.

   Symptoms of sleep-disordered breathing may include:

   - Headaches
   - Lack of energy
   - Daytime sleepiness
   - Snoring
   - Difficulty falling asleep and staying asleep
   - Difficulty breathing while asleep

2. ***What causes Sleep-Disordered Breathing?***
   Snoring and sleep apnea occur when the soft tissue structures of the upper airway collapse, resulting in a narrowed airway opening. The snoring sound is caused by the vibration of these tissues. Complete closure of the airway is an "apnea event," which means that no air is getting into the lungs.

   The causal factors may be:

   - Structural – narrow jaw, large tongue, enlarged tonsils, enlarged adenoids, thick soft palate, small nasal valve, or deviated septum
   - Other factors – allergies, over consumption of alcohol, sedatives, smoking, and disruption of normal sleep patterns, or decreased lung capacity (often caused by obesity)

3. ***What problems can Sleep-Disordered Breathing cause?***
   - Poor performance at work or school
   - Forgetfulness
   - Irritability
   - Depression/Anxiety
   - Workplace or auto accidents
   - High blood pressure
   - Diabetes
   - Stroke
   - Heart failure and heart attack

4. ***How do I know if I am at risk or may have Sleep-disordered Breathing?***
   A helpful diagnostic tool to help determine if you have or are at risk for sleep-disordered breathing is the Epworth Sleepiness Scale **(Please see next page)**.

   A diagnosis of sleep-disordered breathing should be confirmed by a sleep study carried out in a sleep center designed for this type of testing.

5. ***What can be done if I have Sleep-Disordered Breathing?***
   Once it has been determined you have sleep-disordered breathing, a physician will determine treatment which may include:

   - CPAP (continuous positive airway pressure)
   - Surgery
   - Oral sleep appliance

SLEEP-DISORDERED BREATHING

(CONTINUED)

THE EPWORTH SLEEPINESS SCALE

(To assess risk of Obstructive Sleep Apnea)

Use the following scale to choose the most appropriate number for each situation:

0 = **No** chance of dozing
1 = **Slight** chance of dozing
2 = **Moderate** chance of dozing
3 = **High** chance of dozing

Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g., 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	
Total	

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