Patient Form

Parent Name: _____

City: _____ State: _____ Age: _____ Male or Female: _____

Current Dentist: _____ Current Pediatrician: _____

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present 1 – 2 Mild 3 Moderate 4 - 5 Pronounced

Does your child:

INITAL

1. _____ Snore at all?
2. _____ Snore only infrequently (1 night/week)
3. _____ Snore fairly often (2-4 nights/week)
4. _____ Snore habitually (5-7 nights/week)
5. _____ Have labored, difficult, loud breathing at night
6. _____ Have interrupted snoring where breathing stops for 4 or more seconds
7. _____ Have stoppage of breathing more than 2 times in an hour
8. _____ Hyperactive
9. _____ Mouth breathes during day
10. _____ Mouth breathes while sleeping
11. _____ Frequent headaches in morning
12. _____ Allergic symptoms
13. _____ Excessive sweating while asleep

INITAL

14. _____ Talks in sleep
15. _____ Poor ability in school
16. _____ Falls asleep watching TV
17. _____ Wakes up at night
18. _____ Attention deficit
19. _____ Restless sleep
20. _____ Grinds teeth
21. _____ Frequent throat infections
22. _____ Feels sleepy and/or irritable during the day
23. _____ Have a hard time listening and often interrupts
24. _____ Fidgets with hands or does not sit quietly
25. _____ Ever wets the bed
26. _____ Bluish color at night or during the day
27. _____ Speech Problems *

*If yes, provide parent speech questionnaire

Was your reason for coming to this doctor for sleep or dental issues: _____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #27 was indicated above

Please check all that apply to your child:

INITAL

28. _____ Is it difficult to understand your child's speech
29. _____ Difficult to understand over the phone?
30. _____ Nasal speech?
31. _____ Speech sounds abnormal?
32. _____ Others have difficulty understanding speech?

INITAL

33. _____ Gets frustrated when people can't understand speech?
34. _____ Sometimes omits consonants
35. _____ Uses M, N, NG instead of P, F, V, S, Z sounds
36. _____ Hoarseness
37. _____ Lisp
38. _____ Any speech therapy?

How Long? _____

Based on Barr et al, 2007

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Photography & Records Release Form

For valuable consideration received, the receipt and sufficiency of which are hereby acknowledged, I,_____ hereby forever grant to Healthy Start, a company of Ortho-Tain, Inc, its legal representative, successors, assigns, licenses, advertising agencies, and all persons or corporations acting with its permission the irrevocable and unrestricted right to use, re-use, publish and re-publish, and copyright my performance, likeness, picture, portrait, photograph, sound and/or voice recording, including the negatives, transparencies, prints, film, video, tapes, digital or other information pertaining to them in all forms of media now or hereafter known and in all manner, including electronic media, in still, single, multiple, moving or video format, in whole or part and or composite representatives, in conjunction with my own or a fictitious name, including alterations, modifications, derivations and composites thereof, throughout the world and universe for advertising, promotion, trade or any lawful purposes.

This right shall include, but not be limited to, the right to combine my likeness with others and to alter my likeness, by digital means or otherwise, for the purpose set forth herein.

I waive any right to inspect or approve the finished product, including written copy that may be created in connection therewith or the use to which it may be applied.

I acknowledge that the photography session and/or film or video production was conducted in a proper and professional manner, and this release was willingly signed at its termination.

I affirm that I am over the age of majority and that I am fully able to contract in my own name without breach of any prior agreement or applicable law, including but not limited to prior agreements with modeling or talent agencies or any other person, company, or entity.

I have read the above release and agreement, prior to its execution: I fully understand the contents and consequences thereof. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature (if under 18 years of age) Date

_____ _____

Staff Signature Date

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Kid's Contract for Success

Wear Your Appliance as Directed - It is very important that you wear your appliance every night while you sleep and that you follow the doctor's instructions for daytime wear and "exercise".

Fill Out Your Compliance Chart Every Day - Make sure that you record the hours that you are wearing your appliance.

Brush and Floss Your Teeth - Brushing your teeth three times each day and flossing once per day will keep your smile bright and healthy.

Cleaning Your Appliance - Keep your appliance clean by brushing it with warm water and toothpaste each morning. Do not put your appliance in boiling water, the dishwasher, or the microwave.

See Your Dentist and Hygienist for Regular Visits - During your treatment you should continue to visit your dentist and hygienist every 6 months for your cleaning and check-up.

Damage, Breakage or Loss of Appliance - When you are not wearing your appliance, it should be kept safe in the case. Accidents happen, so if your dog eats your appliance, if you lose your appliance, or if you damage your appliance - call the office right away. It is important that we get you a new appliance quickly so that your treatment stays on track.

No Chewing Gum - With Healthy Start, you can eat anything you would like. The only thing you cannot have is gum. Chewing gum will keep your teeth from moving the way that they should.

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature Date

_____ _____

Staff Signature Date

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Consent Form

I hereby consent to and authorize the performance of the Healthy Start System dental procedures upon (name of patient) _____.

Such procedures shall be used as are required in attempting to accomplish the purpose(s) stated above.

I further certify that the dental treatment recommended for me in this document has been thoroughly discussed with me and that I understand my dental treatment needs. I am aware that some changes in the plan may become necessary during the course of treatment, and that, if this is the case, these changes will be explained prior to the time they occur.

I understand that the X-rays, charts, and any other results from this treatment may be used for educational and/or promotional purposes.

I understand that if the patient does not wear the appliance as directed or may have certain adverse physiological conditions that affect successful treatment, which may result in the termination of the treatment procedure.

The nature and purpose of the treatment listed above and any possible risks involved have been fully explained to me.

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature (if under 18 years of age) Date

_____ _____

Staff Signature Date