New Horizons

Dental Associates, PLLC

Dr. Paul M. Churder 1660 Hopkins Road Suite 101 **Dr. Anthony M. Lafornara**
Getzville, NY 14068
Office (716) 689-7713 Fax (716) 689-1002
Email: twosleepdocs@verizon.net

Our office is located at the corner of Hopkins and Dodge Roads. There are no numbers on the building. Look for the Dr. Marti sign…Entrance to our office is in the parking lot facing Dodge Rd. Upon entering building we are the first door on the left.

From the 290:

(fastest /less traffic) Take the exit for 990 (north) toward Lockport. Exit at North French and turn right onto North French.
Proceed through 3 traffic lights, the 3rd light is Hopkins Road, take a right. The next traffic light is the corner of Hopkins Road and Dodge Road. We are BEFORE the intersection on the right across from Rite Aid.

OR

(shorter distance/more traffic) Exit 290 at Millersport North, follow to Dodge, take a right on Dodge and proceed to the stop sign. Follow Dodge (it will veer to your left) our building is before the traffic light at Hopkins.

From Main Street/Sheridan/Maple:

Proceed to Hopkins Road (turn North) past the Hopkins and Klein intersection. We are at the next intersection, Hopkins and Dodge, kitty-corner to Williamsville North and across from Rite Aid.

From Transit:

Turn West onto North French and proceed to the intersection of North French and Hopkins. Take a left onto Hopkins Road. We are after the intersection of Hopkins and Dodge, on your right hand side across from Rite Aid.

From Niagara Falls Blvd:

Niagara Falls Blvd to Robinson; which turns into North French. Proceed past Sweet Home, Campbell and the 990 interchange. Proceed 3 traffic lights after you pass the 990 and the 3rd light is Hopkins Road-turn right. The next traffic light is the corner of Hopkins Road and Dodge Road. We are before the intersection on your right hand side across from Rite Aid.

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INSURANCE INFORMATION FORM

Please fill out the following information so we can efficiently process your insurance claims

PATIENT NAME: ____ **Date:** _____________

MEDICAL INSURANCE CARRIER: _____________________________

SUBSCRIBER #: ____

NAME (if other than patient): ________________________________

DATE OF BIRTH (of subscriber): _____________________________

SLEEP PHYSICIANS NAME: ____________________________________

OFFICE ADDRESS: ____

____

OFFICE TELEPHONE #: ___________________________________

PRIMARY CARE PHYSICIAN'S NAME: ___________________________

OFFICE ADDRESS: ____

____

OFFICE TELEPHONE #: ___________________________________

GENERAL DENTIST'S NAME: ________________________________

OFFICE ADDRESS: ____

____

OFFICE TELEPHONE #: ____________________________

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SLEEP QUESTIONNAIRE

Name: ____ Date: ______________
Age: _____ Sex: M ____ F ____

1. **Are you aware of snoring? ________________________**
2. **Has it caused problems for relatives or friends? _________________________**
3. **Have you been told your breathing stops while sleeping? _________________**
4. **Have you been told you move around a lot while asleep? ________________**
5. **About how many times per night do you wake up? ______________________**
6. **Do you have any difficulty falling asleep at night? ______________________**
7. **How many hours of sleep per night do you get? ________________________**
8. **Do you most often wake up feeling refreshed? __________________________**
9. **Do you often wake up with a headache? ________________________________**
10. **Will a small amount of alcohol give you a hangover? _____________________**
11. **Do you feel sleepy during the day? Frequently Occasionally Seldom Never**
12. **What other doctors have you seen about your snoring or sleep apnea?**
    ____
13. **Have you had a sleep lab study? Yes ____ No ____**
14. **Do you have difficulty breathing through your nose? Yes ____ No ____**
15. **Have you gained weight recently? Yes ____ No ____**
    About how much? __________
16. **Present body weight: ________ Height: ________ft. _________ in.**
17. **What professional advice or treatment have you received about your snoring or sleep apnea?**

____

EPWORTH SLEEPINESS SCALE

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

Situation	**Chance of dozing**
Sitting and Reading	______
Watching TV	______
Sitting, inactive in a public place (e.g. theater or 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 car, while stopped for a few minute in the traffic	______
Total:	______

PATIENT INFORMATION AND HEALTH RECORD

Name: ____ Date of birth: ___________
Address: ____

____ _________

Telephone#
Home: ____________ Office: ________________ Cell: _______________
Email address __________________________@_____________________

Place of employment: ____

In case of emergency contact: ____________________________________
Relation: ____
Telephone #: Home __________________ Office ________________ Cell: _________

Do you pre-medicate for dental visits? Y N

Are you allergic to any drugs? If so, what: __________________________________
Have you been hospitalized or had surgery in the past 2 years? If so, please explain:
____

Are you taking any medications at this time?

Medication	Dosage	Reason for taking
____________________	____________________	___________________
____________________	____________________	___________________
____________________	____________________	___________________
____________________	____________________	___________________
____________________	____________________	___________________

Does your medical history include:

Condition	Y	N	Condition	Y	N
Anemia	Y	N	Alcoholism	Y	N
Arthritis	Y	N	Artificial joint	Y	N
Asthma	Y	N	Cancer	Y	N
Chronic Cough	Y	N	Depression	Y	N
Diabetes	Y	N	Epilepsy	Y	N
Exessive bleeding	Y	N	Fainting	Y	N
Glaucoma	Y	N	Hayfever	Y	N
Heart disease	Y	N	Heart murmer	Y	N
Hepatitis	Y	N	Herpes	Y	N
High blood pressure	Y	N	High cholesterol	Y	N
HIV/aids	Y	N	Jaundice	Y	N
Liver disease	Y	N	Pacemaker	Y	N
Radiation therapy	Y	N	Rheumatic fever	Y	N
Chronic sinus trouble	Y	N	Stroke	Y	N
Tuberculosis/lung disease	Y	N	Ulcer/GERD/acid reflux	Y	N
Venereal disease	Y	N	Are you pregnant?	Y	N
Thyroid Disease	Y	N	Due date ________		

Please add anything you feel is important for your health history:

____
____
____
____
____
____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Persons: Anthony M. Lafornara, D.D.S., F.A.G.D. / Paul M. Churder, D.D.S., F.A.G.D.

Telephone: (716) 689-7713 Fax: (716) 689-1002

E-mail: twosleepdocs@verizon.net

Address: 1660 Hopkins Road, Getzville, NY 14068

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations. I authorize the release of information regarding my health information to Dr. Anthony M Lafornara DDS FAGD.

Signature: ___________________________________ Date: _________________________