New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name:_____ M I: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

The best time to contact me is:

☐ Morning ☐ Mid-Day ☐ Evening on ☐ Home phone ☐ Cell phone ☐ Work phone

Email: _____ Would you like to receive our e-newsletter? ◯ Yes ◯ No

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: ◯ M ◯ F Social Security Number (SSN): _____

Height. Feet: _____ Inches: _____ Weight (lbs): _____

Marital Status: ◯ Married ◯ Single ◯ Life Partner ◯ Minor

Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

REFERRED BY: _____

Employer Information

Employer: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Name of Insured (First, MI, Last): _____ Insured DOB: _____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email:_____

Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? : ◯ YES ◯ NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Primary Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Name of Insured (First, MI, Last): _____ Insured DOB: _____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email:_____

Please present your insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____

ENT: _____ Phone: _____

SLEEP DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

OTHER MD: _____ Phone: _____

OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ DATE _____

Patient Questionnaire

EPWORTH SLEEPINESS SCALE

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

Sitting and reading	0	1	2	3	_____
Watching TV	0	1	2	3	_____
Sitting inactive in public place (theater)	0	1	2	3	_____
As a car passenger for an hour without a break	0	1	2	3	_____
Lying down in the afternoon to rest	0	1	2	3	_____
Sitting and talking to someone	0	1	2	3	_____
Sitting quietly after lunch without alcohol	0	1	2	3	_____
In a car while stopped at a traffic light	0	1	2	3	_____

TOTAL: _____

THORNTON SNORING SCALE

0=Never, 1=1 night/week, 2=2-3 nights/week, 3=4+ nights/week

My snoring affects my relationship with my partner	0	1	2	3	_____
My snoring causes my partner to be irritable or tired	0	1	2	3	_____
My snoring requires us to sleep in separate rooms	0	1	2	3	_____
My snoring is loud	0	1	2	3	_____
My snoring affects people when I am sleeping away from home	0	1	2	3	_____

TOTAL: _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

_____

Do you have other complaints?

- ☐ Frequent snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

Subjective Signs And Symptoms

Rate your overall energy level: (Low) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (Excellent)

Rate your sleep quality: (Low) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (Excellent)

Have you been told you snore? : ○YES ○NO ○SOMETIMES

Rate the sound of your snoring: (Quite) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (Loud)

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches?: ○NEVER ○RARELY ○SOMETIMES ○OFTEN ○EVERYDAY

Do you have a bed partner?: ○YES ○NO ○SOMETIMES

Do you sleep in the same room?: ○YES ○NO

How many times per night does your bedtime partner notice you stop breathing?

○SEVERAL TIMES PER NIGHT ○ONCE PER NIGHT ○SEVERAL TIMES PER WEEK ○OCCASIONALLY ○SELDOM ○NEVER

Have you ever had a sleep study? ..... ○ YES ○ NO

If YES, where and when? _____ Date: _____

Have you tried CPAP? ..... ○ YES ○ NO

Are you currently using CPAP? ..... ○ YES ○ NO

If YES, how many nights per week do you wear it? (/7nights) _____

When you wear your CPAP, how many hours per night do you wear it?(hours per night) _____

If you use or have used CPAP, what are your chief complaints about CPAP?

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort from the straps or headgear
- ☐ Decrease sleep quality or interrupted sleep from CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ Device causes teeth or jaw problems
- ☐ Other _____
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI/stomach/intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Causes dry nose or dry mouth
- ☐ CPAP seems to be ineffective
- ☐ A latex allergy

Are you currently wearing a dental device? ..... ○ YES ○ NO

Have you previously tried a dental device? ..... ○ YES ○ NO

If YES, was it Over the Counter (OTC)? ..... ○ YES ○ NO

Was it fabricated by a dentist? ..... ○ YES ○ NO

If YES, who fabricated it? _____

If applicable, please describe your previous dental device experience: _____

Have you ever had surgery for snoring or sleep apnea? ..... ○ YES ○ NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: _____ SURGEON:_____ SURGERY: _____

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DATE: _____ SURGEON:_____ SURGERY: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.

_____

PRE-MEDICATION- Have you been told you should receive pre-medication before dental procedures? ..... ◯ YES ◯ NO

If YES, what medication(s) and why do you require it? _____

ALLERGENS - Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

_____

MEDICATIONS - Please list all medications you are currently taking:

_____

MEDICAL HISTORY - Please list all medical diagnoses and surgeries from birth until now (for exam pie: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

_____

Dental History

How would you describe your dental health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Have you ever had teeth extracted? ..... ◯ YES ◯ NO

If YES, please describe _____

Do you wear removable partials? ..... ◯ YES ◯ NO

Do you wear full dentures? ..... ◯ YES ◯ NO

Have you ever worn braces (orthodontics)? ..... ◯ YES ◯ NO

If YES, date completed _____

Does your TMJ (jaw joint) click or pop? ..... ◯ YES ◯ NO

Do you have pain in this joint? ..... ◯ YES ◯ NO

Have you had TMJ (jaw joint) surgery? ..... ◯ YES ◯ NO

If YES, have you ever had gum surgery? _____

Do you have dry mouth? ..... ◯ YES ◯ NO

Have you ever had an injury to your head, face, neck, or mouth? ..... ◯ YES ◯ NO

Are you planning to have dental work done in the near future? ..... ◯ YES ◯ NO

Do you clench or grind your teeth? ..... ◯ YES ◯ NO

If you answered YES to any question above, please briefly describe your answer here:

_____

Family History

Have genetic members of your family had:

Heart Disease? ..... ◯ YES ◯ NO High Blood Pressure? ..... ◯ YES ◯ NO Diabetes? ..... ◯ YES ◯ NO

Have genetic members of your family been diagnosed or treated for a sleep disorder? ..... ◯ YES ◯ NO

How often do you consume alcohol within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never

How often do you take sedatives within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never

How often do you consume caffeine within 2-3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely/Never

Do you smoke? ..... ◯ YES ◯ NO If YES, how many packs per day? _____

Do you use chewing tobacco? ..... ◯ YES ◯ NO If YES, how many times per day? _____

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____