

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____
 Address: _____ State: _____ Zip: _____
 City: _____
 Home Telephone: _____ Birth date: _____ Social Security No: _____
 Male Female Married Widowed Divorced Single
 Family Physician: _____ Phone no: _____
 Family Dentist: _____ Phone no: _____
 When was your last dental appointment? _____
 Emergency contact person: _____ Phone no: _____
 Relationship of emergency contact person: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone no: _____
 Employer Address: _____ Your Job title: _____
 Are you presently working? Yes No If no, when was your last day worked? _____
 Have you missed any work due to your present condition? (Please give dates) _____
 The most difficult tasks while at work are/were _____

INSURANCE INFORMATION

Primary Health Insurance {Complete even if you are covered by auto insurance}

Insured: _____ D.O.B.: _____ Relationship: _____
 Insurance Co: _____ Phone: _____
 Billing Address: _____ State: _____ Zip: _____
 City: _____
 Policy/Contract No: _____ Group no: _____

Secondary Health Insurance {Complete even if you are covered by auto insurance}

Insured: _____ D.O.B.: _____ Relationship: _____
 Insurance Co: _____ Phone: _____
 Billing Address: _____ State: _____ Zip: _____
 City: _____
 Policy/Contract No: _____ Group no: _____

Auto Insurance {Complete only if injury is result of an auto accident}

Insured: _____ D.O.B.: _____ Relationship: _____
 Insurance Co: _____ Phone no: _____
 Address: _____
 City: _____ State: _____ Zip: _____ Has this been reported? Yes No
 Claim No: _____ Adjuster: _____ Date of injury: _____

Workers Compensation {Complete only if injury is result of a work related incident}

Employer: _____ Date of Accident: _____
 Address: _____ State: _____ Zip: _____
 City: _____
 Has this been reported? Yes No If yes was treatment authorized? Yes No
 Insurance Co: _____ Phone no: _____
 Address: _____ State: _____ Zip: _____
 City: _____ Claim No: _____
 Adjuster: _____

Dental Insurance {Complete even if you are covered by auto insurance}

Insured: _____ D.O.B.: _____ Relationship: _____
 Insurance Co: _____ Phone: _____
 Address: _____ State: _____ Zip: _____
 City: _____
 Group no: _____ Policy no: _____ Contract no: _____

Patient Signature: _____ Date: _____

PAST MEDICAL HISTORY: (CIRCLE THOSE CONDITIONS THAT APPLY)

GERD Trauma to Head, Face or Neck AIDS/HIV Allergies
High Blood Pressure Heart Problem Anemia Hepatitis
Thyroid Problem Back Problem Neck Stiffness Cancer
Immune System Disorder Rheumatic Disorder Fibromyalgia
Depression Chronic Pain Previous Surgery Menopause
Muscle Spasm/Cramps Diabetes Arthritis Asthma Herpes
Artificial Body Part Arteriosclerosis Liver Disease Pacemaker
Kidney Disease Sinus problem Emphysema Epilepsy
Prolonged Cough Prolonged Bleeding Other_____

PHYSICAL CONDITIONS: Weight_____ Height_____ft_____inches
Blood Pressure_____ Neck Size_____

SLEEP DISORDER SYMPTOMS: (CIRCLE THOSE CONDITIONS THAT APPLY)

Excessive Daytime Sleepiness Nighttime Choking Difficulty Initiating Sleep
Awaken Gasping Unrefreshing Sleep Esophageal Reflux Loud Snoring
Drooling Sleep Paralysis Heartburn Frequent Nocturnal Urination
Limb Movement Nightmares/Terrors Sleep Hallucinations Tooth Clenching
Frequent Panic Attacks Crying Spells Insomnia Cataplexy/Muscular Rigidity
Memory Loss Delayed Sleep Onset Depression Restless Legs
Difficulty concentrating Night Sweats Frequent Sleep Arousals/Awakenings
Sleep Walking Sleep Talking Bruxism / Nocturnal Tooth Grinding

HISTORY:

- • Have you had a weight change greater than 5 pounds in the last year?..... NO / YES (if yes then answer appropriately) Gained _____lbs
Lost _____lbs
- • Do you have difficulty breathing through your nose at night?..YES NO
- • Have you ever been treated for difficulty breathing through your nose?..YES NO
- • If you awaken during the night, is it difficult to fall back asleep?.....YES NO
- • During an average night, how many times do you awaken? 1 2 3 4 5 6 7 8
- • On the average, how many hours do you sleep a night? 1 2 3 4 5 6 7 8 9 10
- • Have immediate family members had sleep disorders?.....YES NO
- • Do you have difficulty finding the energy to do your daily activities?.....YES NO
- • Circle your usual sleep position or positions... *back side stomach varies*
- • How often do you consume alcohol? *never once/week several times/week daily*
- • How often do you consume alcohol within two hours of bedtime?.....
never once/week several times/week daily
- • Do you frequently wake up in the morning with a headache or get one shortly after awakening?.....YES NO

APNEA PATIENTS

- • Have you ever had a sleep study?.....YES NO
- • Did you receive a diagnosis of obstructive sleep apnea?.....YES NO
- • If yes, name of doctor making the diagnosis_____
- • If yes, specialty of health care provider making the diagnosis?_____
- • If yes, what was your Apnea-Hypopnea Index?_____
- • Name and location of Sleep Lab_____

- • Has a CPAP (*Continuous Positive Airway Pressure*) Device ever been recommended?YES NO

- • If you answered yes and found you could not tolerate it, *circle the reasons below*

Mask Leaks Improper Mask Fit Discomfort from Straps / Headgear
 Bloating Feeling Disturbed Sleep from Device Noise CPAP Restricted Movements
 CPAP Ineffective Pressure on Upper Lip Caused Tooth Discomfort Latex Allergy
 Claustrophobic Associations Disturbed Bed Partner's Sleep Worsened Sleep Quality
 Other _____

- • Circle or itemize other therapies performed to help your sleep apnea:

Exercise Palatal Surgery Nasal Surgery Tongue Surgery
 Smoking Cessation Mandibular Advancement Oral Device Maxilla Surgery
 Tongue Retaining Device Weight Loss

EPWORTH SCALE:

This questionnaire tells us how likely you are to doze off or fall asleep in the following situations, in contrast to just feeling tired. Your answers refer to your usual way of life in recent times. Even if you have not experienced some of these things recently, estimate how they would affect 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

SITUATION CHANCE OF DOZING

Sitting and reading.....
 Watching Television.....
 Sitting inactive in public
e.g. theater or meeting.....
 As passenger in a car for an
 hour without a break.....
 Lying down to rest in the
 afternoon when able.....
 Sitting and talking to someone.....
 Sitting quietly after lunch
 without alcohol.....
 In a car stopped momentarily
 in traffic.....

TOTAL _____

It may be important for us to communicate our recommendations for you with other doctors. Please list all of the names and addresses of doctors that you are currently seeing, even if it is not for pain.

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N



Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- * A basis for planning my care and treatment
- * A means of communication among the many health professionals who contribute to my care
- * A source of information for applying my diagnosis and surgical information to my bill
- * A means by which a third-party payer can verify that services billed were actually provided, and
- * A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information used and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

Signature

Date

For office use only

Consent received by _____ on _____

Consent refused by patient, and treatment refused as permitted

Consent added to the patient's medical record on _____