

Patient Registration

Please fill in completely

Name: _____ Gender: Male Female Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

E-Mail address: _____ Preferred form of contact: _____

Birth date: _____ Social Security Number: _____

Employer: _____

How did you hear about our office? _____

Present dentist: _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Date of last visit: _____

Present physician: _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Are you now under the care of a physician? Yes No If yes, for what reason?

Health Insurance Information

Medical Insurance Company: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Social Security #: _____ DOB: _____

Records release: I hereby authorize the Snoring and Sleep Apnea Dental Treatment Center to release my information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patient (or parent if minor)

Signature: _____ Date: _____

Initial Evaluation Questionnaire

Date: ____/____/____
Mo. Day Year

Code Number: _____

Sex: 1 Male 2 Female

Date of Birth: ____/____/____ Age: _____
Mo. Day Year

Marital Status: 01 Single 05 Widowed
 02 Married 06 Divorced and remarried
 03 Divorced 07 Domestic partner
 04 Separated

Race: 1 Caucasian 3 Asian 5 Other (specify): _____
 2 African American 4 Hispanic

Is there usually a bed partner to observe your sleep?: 1 Yes 2 No

During the last week:

	Never	Rarely	Some- times	Often
1. Have you snored or have you been told that you do?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Have you had choking or shortness of breath sensations at night?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Have you woken up during sleep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Have you had morning fatigue or fogginess or woken up feeling unrefreshed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Have you woken up with a headache?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Have you had chronic sleepiness, fatigue or weariness that you can't explain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Have you fallen asleep during the day, particularly when not busy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Have you fallen asleep reading or watching television?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Have you fallen asleep during the day against your will?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Have you had to pull off the road while driving due to sleepiness?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. Have you been more irritable and short-tempered?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. Have you felt your memory and/or intellect is impaired?	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		
13. Have you been told that you stop breathing while asleep?	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		

Questionnaire for Sleep Apnea and/or Snoring

(use back if more spaces is needed)

Name: _____ Date: _____

1. How long have you been aware of your snoring? _____

2. Has it caused problems for relatives or friends? _____

3. Have you been told your breathing stops while asleep? _____

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. _____ inches

17. What professional advice or treatment have you received about your snoring or sleep apnea?

Signature: _____ Date: _____

The Epworth Sleepiness Scale

Name: _____

Today's Date: _____

Your Age (years): _____

Your Sex: ___ Male ___ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected 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 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 a car, while stopped for a few minutes in the traffic	_____

Thank you for your cooperation !

Personal Medical, Family and Social History with Review of Systems

Name: _____ Date: _____

Do you have or have you had any pain in any of the following areas?

[Please circle any that apply] Jaw Ear Face Neck Teeth Headaches

Other: _____

Does your jaw make any of the following noises?

[Please circle any that apply] Clicking Popping Rubbing Grinding Crunching

Other: _____

Have you received treatment for any TMJ, head, or neck symptoms? Yes No

When was your last dental visit? _____

Have you been told that you have periodontal (gum) disease? Yes No

Do you have any existing problems with your teeth? Yes No

Describe: _____

Is any dental treatment planned? Yes No

Personal Medical History

General

Change in Appetite..... Y N
 Fever..... Y N
 General Weakness..... Y N
 Marked Weight Change..... Y N
 Night Sweats..... Y N
 Polyuria (frequent urination)..... Y N
 Recent Trauma or Injury..... Y N
 Unusual Weakness..... Y N
 Chronic Fatigue Syndrome..... Y N
 Hepatitis..... Y N
 Tumors/cancer..... Y N
 HIV/AIDS..... Y N

Allergies

Anaphylactic reaction..... Y N
 Dairy..... Y N
 Dust..... Y N
 Excessive sneezing..... Y N
 Hay Fever..... Y N
 Latex..... Y N
 Penicillin..... Y N
 Sulpha drugs..... Y N
 Wheat..... Y N

Neurological

Confusion..... Y N
 Dizziness..... Y N
 Fainting..... Y N
 Memory Loss..... Y N
 Muscle weakness..... Y N

Seizures..... Y N
 Stroke..... Y N
 Tingling/Numbness..... Y N
 Tremor..... Y N
 Alzheimer's Disease..... Y N
 Multiple Sclerosis (MS)..... Y N

Skin

Acne..... Y N
 Frequent bleeding..... Y N
 Bruising..... Y N
 Eczema..... Y N
 Itch..... Y N
 Lesions..... Y N
 Psoriasis..... Y N

Endocrine

Diabetes..... Y N
 Gout..... Y N
 Hormonal Changes..... Y N
 Thyroid problems..... Y N

Eyes, Ears, Nose and Throat

Change in hearing..... Y N
 Change in Smell..... Y N
 Dysphagia (difficulty swallowing)..... Y N
 Ear Pain..... Y N
 Glaucoma..... Y N
 Hearing loss..... Y N
 Hoarseness..... Y N
 Nasal Discharge..... Y N

EENT- cont. Y N
 Sinus problems.....Y N
 Tinnitus (ringing in ears).....Y N
 Visual Changes.....Y N

Cardiovascular

Coronary Artery Disease.....Y N
 Chest pain.....Y N
 Congstive Heart Failure.....Y N
 Heart Attack.....Y N
 Heart Murmur.....Y N
 High Blood Pressure.....Y N
 High Cholesterol.....Y N
 Irregular Heart Beat.....Y N
 Tachycardia (rapid heart beat).....Y N

Respiratory

Asthma.....Y N
 Bronchitis.....Y N
 Chest pressure.....Y N
 Colored sputum.....Y N
 Congestion.....Y N
 Cough.....Y N
 Dyspnea (shortness of breath).....Y N
 Emphysema.....Y N
 Hemoptysis (coughing up blood).....Y N
 Hypoventilation Syndrome.....Y N
 Orthopnea (shortness of breath while supine).....Y N
 Pneumonia.....Y N
 Pulmonary embolism.....Y N
 Shortness of breath.....Y N
 Tuberculosis.....Y N

Gastrointestinal

Black or bloody stool.....Y N
 Constipation.....Y N
 Diarrhea.....Y N
 GERD.....Y N
 Irritable Bowel Syndrome.....Y N
 Stomach pain.....Y N
 Ulcers.....Y N
 Vomiting.....Y N

List any medications you are taking: Dosage

Nasal Obstruction.....Y N
 Nose Bleeding.....Y N

Genitourinary

Frequent Urination.....Y N
 Hematuria (blood in urine).....Y N
 Incontinence.....Y N
 Kidney Infections.....Y N
 Kidney Stones.....Y N
 Kidney Disease.....Y N
 Prostate problems.....Y N
 Cervical/Uterine/Ovarian/Breast Cancer.....Y N
 Currently pregnant?.....Y N

Psychiatric

ADD/ADHD.....Y N
 Anxiety.....Y N
 Autism.....Y N
 Depression.....Y N
 Disorientation.....Y N
 Excess Stress.....Y N
 Hallucination.....Y N
 Memory problems.....Y N
 Eating Disorders.....Y N
 Chemical Dependency.....Y N

Musculoskeletal

Back pain.....Y N
 Fibromyalgia.....Y N
 Joint pain.....Y N
 Limited range of motion.....Y N
 Muscle Atrophy.....Y N
 Muscle pain.....Y N

Social History

Do you smoke? N Y _____ packs a day

Do you consume alcoholic beverages?
 _____ Drinks per day/week/month

List any surgeries you have had:

List any Vitamins/Supplements you are taking:

I certify that the above information is correct to the best of my knowledge.

Patient signature: _____ Date: _____

[Patient or guardiang, if patient is a minor]

DDS signature: _____

Bed Partner/Witness Screening Questionnaire: Obstructive Sleep Apnea

Name: _____

Person completing form: _____ Date: ____/____/____

Please answer the following questions as they pertain to your bed partner in the past month.

1. While sleeping, does your partner:

Snore more than half the time?.....Y N DK
Always snore?.....Y N DK
Snore loudly?.....Y N DK
Have “heavy” or loud breathing?.....Y N DK
Have trouble breathing, or struggle to breathe?.....Y N DK

2. Have you ever seen your partner stop breathing during the night?.....Y N DK

3. Does your bed partner ever have snorting or choking episodes during the night?.....Y N DK

4. Does your partner:

Tend to breathe through the mouth?.....Y N DK
Have a dry mouth on waking up in the morning?.....Y N DK
Occasionally wet the bed?.....Y N DK

5. Have you ever experienced your partner:

Grinding their teeth during the night?.....Y N DK
Have twitching or kicking of their legs or arms?.....Y N DK

6. Does your partner:

Wake up feeling unrefreshed in the morning?.....Y N DK
Have a problem with sleepiness during the day?.....Y N DK

7. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day?.....Y N DK

8. Is it hard to wake your partner up in the morning?.....Y N DK

9. Does your partner wake up with headaches in the morning?.....Y N DK

10. Is your partner overweight?.....Y N DK

Billing and Insurance Policy

The Snoring and Sleep Apnea Dental Treatment Center, Ltd. would like to thank you for choosing us as your provider. We are committed to you and your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

In-network Providers

We are providers for most Medica and Preferred One Health plans. We will expect payment of any applicable co-payments at the time of service. Our office does reserve the right to charge a \$5 late fee for unpaid co-payments.

Out-of-network Providers

If you have coverage through any other insurance carriers, payment in full will be due at the time of service. We will send all claims to your insurance company and they will send all payments or correspondence to you directly. If needed, we will be happy to assist you in getting reimbursement. Some insurance plans require a referral from your Primary Care Clinic or Physician before you can receive coverage. If your plan requires a referral you will need to contact your Primary Care Clinic to make sure that all appropriate referrals are in place prior to starting treatment.

We strongly recommend that you contact your insurance company prior to treatment to confirm the amount or percent of coverage for your care in this office. Your insurance company may ask you for a CPT or HCPCS code for the treatment. The billing code for an oral apnea appliance is E0486. It is important that you confirm your financial responsibility before we begin treatment to avoid any misunderstandings.

I have read, understand and agree to follow the policies as stated above.

Signature_____ Date_____