Patient Registration

FORM DATE: ___/___/_____

Patient ID: _____ Chart ID: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ _____

First Name **Middle Initial** **Last Name**

Other Physician Name

Responsible Party (If someone other than patient)

Name

Patient Information

Street Address

City State Zip

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ___/___/_____ Social Security Number _____-_____-_____

E-mail Spouse Name

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: Feet Inches

☐ Allow Spouse to Review Records

Family Dentist

Medical Insurance Information

Primary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID No. Insured Birth Date ___/___/_____ Plan Name

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Secondary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Insurance Plan or Program Name

Insured Birth Date ____/____/_____ Sex: ☐ Male ☐ Female Insurance ID No.

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____

Version: SLPQV2

Sleep History/Exam/Workup Questionnaire

OFFICE USE
Patient ID:____

NAME: _____ CURRENT DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

Referring Physician: Contact ID:

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

2. Then rate your complaints for frequency and intensity:

Frequency
1-SELDOM 2-OCCASIONAL 3-FREQUENT 4-EVERYDAY

Intensity
0=NO PAIN and 10 is MOST SEVERE PAIN

Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10	Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
☐	CPAP intolerance	☐	☐	☐	Impaired thinking	☐	☐
☐	Difficulty concentrating	☐	☐	☐	Insomnia	☐	☐
☐	Excessive daytime sleepiness	☐	☐	☐	Morning headaches	☐	☐
☐	Fatigue	☐	☐	☐	Nighttime choking spells	☐	☐
☐	Forgetfulness	☐	☐	☐	Snoring which affects the sleep of others	☐	☐
☐	Frequent snoring	☐	☐	☐	Witnessed cessation of breathing	☐	☐
☐	Gasping causing waking up	☐	☐				

Other: Write In

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theater or a 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

Patient Signature: Date:

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: _____

Sleep Study Date: ____/____/_____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of _____

The evaluation showed:

	during REM		*Supine*	*Side*
an RDI of				
an AHI of				

a nadir SpO_2 of ____ T90 ____ ODI ____ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Additional Questions

☐ Yes ☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: _____

CPAP Intolerance

(Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

☐ Refuses CPAP	☐ Noise disturbing sleep and/or bed partner's sleep	☐ Claustrophobic associations
☐ Mask leaks	☐ CPAP restricted movements during sleep	☐ An unconscious need to remove the CPAP
☐ Inability to get the mask to fit properly	☐ CPAP does not seem to be effective	☐ Does not resolve symptoms
☐ Discomfort from headgear	☐ Pressure on the upper lip causing tooth related problems	☐ Noisy
☐ Disturbed or interrupted sleep	☐ Latex allergy	☐ Cumbersome

Patient Signature: _____ Date: _____

CPAP Intolerance

(Continuous Positive Airway Pressure device)

Other

Other Therapy Attempts

include:

- ☐ Dieting
- ☐ Weight loss
- ☐ Surgery (Uvuloplasty)
- ☐ Surgery (Uvulectomy)
- ☐ Pillar procedure
- ☐ Smoking cessation
- ☐ CPAP
- ☐ BiPAP
- ☐ Uvulectomy (but continues to have symptoms)
- ☐ Uvuloplasty (but continues to have symptoms)
- ☐ Positional therapy (side sleeping)
- ☐ Nasal strips

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Sleep History

Previous Diagnosis

Have you been previously diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, how long ago was it? ☐ *number* ☐ Years ago ☐ Months ago ☐ Days ago

Sleep:

Sleep Onset Latency ☐ minutes

Normally goes to bed at ☐ ☐ AM PM

Hours of sleep per night ☐ hours

☐ Gasping

☐ Getting up <# of times> per night

Sleep Aid ☐ Yes ☐ No

If yes, name the medication:

☐ Bruxism (grinding teeth)

☐ Dry mouth

☐ Excessive movements

Patient Signature:

Date:

Sleep History

Witnessed apneas are:

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

- ☐ Awakens unrefreshed
- ☐ Has morning headaches

Naps

- ☐ naps daily
- ☐ never naps
- ☐ occasionally naps
- ☐ _____

Snoring is reported as:

Frequency

- ☐ seldom
- ☐ never
- ☐ daily
- ☐ often
- ☐ nightly
- ☐ _____

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Severity

- ☐ light
- ☐ moderate
- ☐ loud
- ☐ _____

Patient Signature

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Patient Signature: _____ Date: _____

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Medical History Questionnaire

OFFICE USE
Patient ID:____

NAME: _____

FORM DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Acid reflux	☐	☐		☐	Blood pressure - Low	☐	☐	
☐	Anemia	☐	☐		☐	Bruising easily	☐	☐	
☐	Atherosclerosis	☐	☐		☐	Cancer	☐	☐	
☐	Arthritis	☐	☐		☐	Chemotherapy	☐	☐	
☐	Asthma	☐	☐		☐	Chronic fatigue	☐	☐	
☐	Autoimmune disorder	☐	☐		☐	Chronic pain	☐	☐	
☐	Bleeding easily	☐	☐		☐	COPD	☐	☐	
☐	Blood pressure - High	☐	☐		☐	Coronary heart disease	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current Never	Past	Date / Note	Significant	Medical Condition	Current Never	Past	Date / Note
☐	Current pregnancy	☐	☐		☐	Liver disease	☐	☐	
☐	Depression	☐	☐		☐	Meniere's disease	☐	☐	
☐	Diabetes	☐	☐		☐	Mitral valve prolapse	☐	☐	
☐	Difficulty sleeping	☐	☐		☐	Mood disorder	☐	☐	
☐	Dizziness	☐	☐		☐	Multiple sclerosis	☐	☐	
☐	Emphysema	☐	☐		☐	Muscular dystrophy	☐	☐	
☐	Epilepsy	☐	☐		☐	Nasal allergies	☐	☐	
☐	Excessive Daytime Sleepiness	☐	☐		☐	Neuralgia	☐	☐	
☐	Fibromyalgia	☐	☐		☐	Osteoarthritis	☐	☐	
☐	Glaucoma	☐	☐		☐	Osteoporosis	☐	☐	
☐	Gout	☐	☐		☐	Parkinson's disease	☐	☐	
☐	Heart attack	☐	☐		☐	Prior orthodontic treatment	☐	☐	
☐	Heart murmur	☐	☐		☐	Radiation treatment	☐	☐	
☐	Heart pacemaker	☐	☐		☐	Rheumatic fever	☐	☐	
☐	Heart valve replacement	☐	☐		☐	Rheumatoid arthritis	☐	☐	
☐	Hemophilia	☐	☐		☐	Sinus problems	☐	☐	
☐	Hepatitis	☐	☐		☐	Sleep apnea	☐	☐	
☐	Hypertension	☐	☐		☐	Stroke	☐	☐	
☐	Hypoglycemia	☐	☐		☐	Tendency for ear infections	☐	☐	
☐	Immune system disorder	☐	☐		☐	Thyroid disorder	☐	☐	
☐	Insomnia	☐	☐		☐	Tuberculosis	☐	☐	
☐	Ischemic heart disease (reduced blood supply)	☐	☐		☐	Tumors	☐	☐	
☐	Kidney problems	☐	☐		☐	Urinary disorders	☐	☐	

Other

Medical Condition	Current	Past	Date / Note	Medical Condition	Current	Past	Date / Note
☐	☐	☐		☐	☐	☐	

Patient Signature: _____ Date: _____

Confidential Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Recreational drugs	☐	☐	☐					
☐	HIV/AIDS	☐	☐	☐					

Surgical Operations

☐ Appendectomy
☐ Back
☐ Ear
☐ Gallbladder
☐ Heart
☐ Hernia repair
☐ Lung
☐ Nasal
☐ Thyroid
☐ Tonsillectomy
☐ Uvulectomy
☐ Periodontal

Other

Family History

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer
☐ Heart disease
☐ Diabetes
☐ High blood pressure
☐ Stroke
☐ Sleep disorder
☐ Obesity
☐ Thyroid disorder
☐ Father snores
☐ Mother snores
☐ Father has sleep apnea
☐ Mother has sleep apnea

Social History

Patient's Occupation

Employer

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit

# of packs per day

# of years

When did you quit?

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week:

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day:

Additional:

☐ Regular exercise

Patient Signature:

Date: