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Patient Consent

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.

☐ **Check here to approve consent**

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Secure Patient Registration

Continue Previous Questionnaire

* = Required

First Name: *

Middle:

Last Name: *

Title:

SSN : ___-__-____

Birthdate: (MM/DD/YYYY) __/__/____ *

E-Mail:

*Address(1): *

Address (2):

*City: *

*State/Province *

*Postalcode/Zip: *

Home Phone (with area code):

Cell Phone:

Work Phone:

Marital:

Gender: *

Height: Ft

In

Allow Spouse to Review Records

This form is intended to be completed in one sitting. After 45 minutes on a page the session will time-out and you will need to restart the form. Any information sent is encrypted and will be securely retrieved by your doctor once completed.

Begin Questionnaire

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Medical Insurance Information

* = Required

Payer Name: (ex. Aetna Insurance)

Address 1:

Address 2:

City/State/Zip:

Insurance Type None

Member ID #

Patient's Relationship to Insured Self

Please complete the subscriber's insurance information below (the person who pays for the insurance)

Name of Insured: First Mid Last

Policy/Group No.

Insured's Birth Date: (MM/DD/YYYY) Gender: Female

Address:

City: State/Province: Postalcode/Zip:

Insured's Telephone (include area code) ___-____

Insurance Plan Name or Program Name

Is There Another Benefit or Plan ○ Yes ○ No

Other Insured's Name: First Mid Last

Other Insurance Policy/Group No.

Insurance Plan Name or Program Name

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Chief Complaints

Please check off your chief complaints

- ☐ CPAP intolerance
- ☐ Difficulty concentrating
- ☐ Excessive daytime sleepiness
- ☐ Fatigue
- ☐ Forgetfulness
- ☐ Frequent snoring
- ☐ Gasping causing waking up
- ☐ Impaired thinking
- ☐ Insomnia
- ☐ Morning headaches
- ☐ Nighttime choking spells
- ☐ Snoring which affects the sleep of others
- ☐ Witnessed cessation of breathing

Type in any other complaints:

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Allergens

List any medications/substances that have caused an allergic reaction:

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

Other Allergens

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Current Medications

Enter all medications you are currently taking:

Medicine

Add New

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Medical History

Item	Never	Current	Past	Date
Acid reflux	☐	☐	☐	
Anemia	☐	☐	☐	
Atherosclerosis	☐	☐	☐	
Arthritis	☐	☐	☐	
Asthma	☐	☐	☐	
Autoimmune disorder	☐	☐	☐	
Bleeding easily	☐	☐	☐	
Blood pressure - High	☐	☐	☐	
Blood pressure - Low	☐	☐	☐	
Bruising easily	☐	☐	☐	
Cancer	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Chronic fatigue	☐	☐	☐	
Chronic pain	☐	☐	☐	
COPD	☐	☐	☐	
Coronary heart disease	☐	☐	☐	
Current pregnancy	☐	☐		
Depression	☐	☐	☐	
Diabetes	☐	☐	☐	
Difficulty sleeping	☐	☐	☐	
Dizziness	☐	☐	☐	
Emphysema	☐	☐	☐	
Epilepsy	☐	☐	☐	
Excessive Daytime Sleepiness	☐	☐	☐	
Fibromyalgia	☐	☐	☐	
Glaucoma	☐	☐	☐	
Gout	☐	☐	☐	
Heart attack	☐	☐	☐	
Heart murmur	☐	☐	☐	

Heart pacemaker	☐	☐	☐
Heart valve replacement	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis	☐	☐	☐
Hypertension	☐	☐	☐
Hypoglycemia	☐	☐	☐
Immune system disorder	☐	☐	☐
Insomnia	☐	☐	☐
Ischemic heart disease (reduced blood supply)	☐	☐	☐
Kidney problems	☐	☐	☐
Liver disease	☐	☐	☐
Meniere's disease	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Mood disorder	☐	☐	☐
Multiple sclerosis	☐	☐	☐
Muscular dystrophy	☐	☐	☐
Nasal allergies	☐	☐	☐
Neuralgia	☐	☐	☐
Osteoarthritis	☐	☐	☐
Osteoporosis	☐	☐	☐
Parkinson's disease	☐	☐	☐
Prior orthodontic treatment	☐	☐	☐
Radiation treatment	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sinus problems	☐	☐	☐
Sleep apnea	☐	☐	☐
Stroke	☐	☐	☐
Tendency for ear infections	☐	☐	☐
Thyroid disorder	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors	☐	☐	☐
Urinary disorders	☐	☐	☐

Enter any other conditions

Additional Information

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Surgeries

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

Additional Information

Other Surgeries

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Family History

Has any member of your family 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

Additional Information

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Social History

Current Occupation

Current Employer

- Never smoked
- Currently smoking

Packs per day

Years smoking

- Quit smoking

Date You Quit Smoking

- Smokes pipe
- Smokes cigars
- Uses snuff
- Uses chewing tobbaco

Do you drink alchohol? Yes No

Drinks per week

Do you drink coffee/tea/soda? Yes No

Cups per day

Additional Items

- Regular exercise

Additional Information

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CPAP Intolerance

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

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

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Other Therapy Attempts

What other therapies have you had?

- ☐ 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

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Epworth

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

None	Slight	Moderate	High	
◉	○	○	○	Sitting and Reading
◉	○	○	○	Watching TV
◉	○	○	○	Sitting inactive in a public place (e.g. a theatre 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
◉	○	○	○	Sitting quietly after a lunch without alcohol
◉	○	○	○	In a car, while stopped for a few minutes, in traffic

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