Patient Registration

FORM DATE: ___/___/_____

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

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

Primary Care Physician ____

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: ____

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	☐	☐		☐	Bruising easily	☐	☐	
☐	Anemia	☐	☐		☐	Cancer	☐	☐	
☐	Atherosclerosis	☐	☐		☐	Chemotherapy	☐	☐	
☐	Arthritis	☐	☐		☐	Chronic fatigue	☐	☐	
☐	Asthma	☐	☐		☐	Chronic pain	☐	☐	
☐	Autoimmune disorder	☐	☐		☐	COPD	☐	☐	
☐	Bleeding easily	☐	☐		☐	Coronary heart disease	☐	☐	
☐	Blood pressure - High	☐	☐		☐	Current pregnancy	☐	☐	
☐	Blood pressure - Low	☐	☐		☐	Depression	☐	☐	

Patient Signature: _____ Date: _____

Medical History

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

Other

Family History

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

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

Social History

Patient's Occupation Employer

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit
# of packs per day When did you quit?
# of years

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:

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: SLPQV1

Sleep Screening Questionnaire

OFFICE USE
Patient ID:

NAME: _____

CURRENT DATE: ___/___/_____ ☐MALE

DATE OF BIRTH: ___/___/_____ ☐FEMALE

Referring Physician: Contact ID:

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

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

Number #1 = the most severe symptom		Number #1 = the most severe symptom	
☐	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

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

Patient Signature: Date:

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

Other

Other Therapy Attempts

include:

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

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
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

Patient Signature: Date:

Patient Signature

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Patient Signature: _____ Date: _____

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

Patient Signature: _____ Date: _____