

Patient Registration

TODAY'S DATE _____

ID: _____ Chart ID: _____

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

Other Dentists if applicable _____

Other Physician Name _____

Whom may we thank for referring you to our practice? _____

Responsible Party (If someone other than the patient) _____

First Name _____ Last Name _____ Middle Initial _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext: _____ Cell Phone _____

Birth Date _____ Soc Sec # _____ Driver License _____

Patient Information _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext: _____ Cell Phone _____

Male Female Married Single Divorced Separated Widowed

Birth Date _____ Soc Sec # _____ Driver License _____

E-mail _____ Spouse Name _____

Occupation _____ Employer Name _____

Employment Status Full Time Part Time Retired Height Feet _____ Inches _____

Student Status Full Time Part Time Weight _____

Medicaid ID _____ Preferred Dentist _____

Employer ID _____ Preferred Pharmacy _____

Carrier ID _____ Preferred Hygienist _____

INSURANCE INFORMATION

Primary Insurance Information _____

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Relationship to insured Self Spouse

Insurance ID No. _____ Child Other

Insured Soc Sec No. _____ Insured Birth Date _____

Employer _____

Ins. Company _____

Insured Address if different than patient's

Street Address _____

Street Address _____

City, State, Zip _____

City, State, Zip _____

Telephone _____

Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____
First Middle Initial Last

TODAY'S DATE _____

DATE OF BIRTH: _____

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching diagnosis and determining the source of your problem. Please take your time and answer each question a completely and honestly as possible. Please sign each page.

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y <input type="checkbox"/>	N <input type="checkbox"/>	Antibiotics	Y <input type="checkbox"/>	N <input type="checkbox"/>	LATEX	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sedatives
Y <input type="checkbox"/>	N <input type="checkbox"/>	Aspirin	Y <input type="checkbox"/>	N <input type="checkbox"/>	Local anesthetics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sleeping pills
Y <input type="checkbox"/>	N <input type="checkbox"/>	Barbiturates	Y <input type="checkbox"/>	N <input type="checkbox"/>	NICKEL	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sulfa drugs
Y <input type="checkbox"/>	N <input type="checkbox"/>	Codeine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Penicillin			
Y <input type="checkbox"/>	N <input type="checkbox"/>	Iodine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Plastic			

Other _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason	Medication name	Dosage/ Frequency	Reason
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICAL HISTORY: (Please indicate dates on items marked current or past)

Medical condition	Never	Current	Past	If past, enter date	Medical condition	Never	Current	Past	If past, enter date
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meniere's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Needing extra pillows to help breathing at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brittle fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronically tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prior orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature _____

Date _____

Medical condition	Never	Current	Past	If past, enter date
Diabetes				_____
Chronic fatigue				_____
Cold sores				_____
Chronic pain				_____
Difficulty concentrating				_____
Difficulty sleeping				_____
Dizziness				_____
Cold hands and feet				_____
Emphysema				_____
Epilepsy				_____
Fainting spells				_____
Fast pulse				_____
Fatigue easily				_____
Fibromyalgia				_____
Gall bladder problems				_____
Glaucoma				_____
Excessive thirst				_____
Hay fever				_____
Hearing impaired				_____
Heart attack				_____
Heartburn				_____
Heart disease				_____
Fluid retention				_____
Heart murmur				_____
Frequent cough				_____
Heart pacemaker				_____
Frequent illnesses				_____
Heart palpitations				_____
Frequent nose bleeds				_____
Heart problems				_____
Frequent stressful situations				_____
Heart valve replacement				_____
Frequent urination				_____
Hemophilia				_____
Hepatitis				_____
General anesthesia				_____
Immune system disorder				_____
Infectious mononucleosis				_____
Gout				_____
Injury to face				_____
Hand tremors				_____
Injury to mouth				_____
Injury to neck				_____
Injury to teeth				_____
Insomnia				_____
Intestinal disorders				_____
Jaw joint surgery				_____
Kidney problems				_____

Current Past If past, enter date

Medical condition	Never	Current	Past	If past, enter date
Radiation treatment				_____
Rheumatic fever				_____
Rheumatoid arthritis				_____
Low energy				_____
Scarlet fever				_____
Scoliosis				_____
Shortness of breath				_____
Menopausal problems				_____
Sinus problems				_____
Menstrual cramps				_____
Sleep apnea				_____
Menstrual irregularity				_____
Stroke				_____
Swallowing problems				_____
Muscle aches				_____
Swelling in ankles or feet				_____
Muscle shaking (tremors)				_____
Tendency for ear infections				_____
Muscle spasms or cramps				_____
Thyroid disorder				_____
Tonsils Removed				_____
Tuberculosis				_____
Tumors				_____
Nervous system irritability				_____
Ulcers				_____
Wisdom teeth (third molar) extraction				_____
Neuralgia				_____
Numbness of fingers				_____
Ovarian cysts				_____
Painful urination				_____
Poor digestion				_____
Prostate problems				_____
Reactions to lead/mercury				_____
Skin disorder				_____
Skin rash				_____
Slow healing sores				_____
Speech difficulties				_____
Stomach gas				_____
Swollen hands				_____
Swollen, stiff or painful joints				_____
Tendency for frequent colds				_____
Tendency for sore throats				_____
Tired muscles				_____
Urinary disorders				_____
Wear glasses or contacts				_____

Current Past If past, enter date

Patient Signature _____

Date _____

Secondary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Relationship to insured Self Spouse

Insurance ID No. _____ Child Other

Insured Soc Sec No. _____ Insured Birth Date _____

Employer _____

Ins. Company _____

Insured Address if different than patient's

Street Address _____

Street Address _____

City, State, Zip _____

City, State, Zip _____

Telephone _____

Sleep Consultation

OFFICE USE Patient ID: _____

NAME: _____
First Middle Initial Last

TODAY'S DATE _____

DATE OF BIRTH: _____ MALE FEMALE

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	Frequency	Intensity
<i>#1 = the most severe symptom</i>	1-4	1-10
SLEEP BREATHING COMPLAINTS	_____	_____
_____ CPAP Intolerance	_____	_____
_____ Difficulty Falling Asleep	_____	_____
_____ Difficulty Swallowing	_____	_____
_____ Fatigue	_____	_____
_____ Frequent Heavy Snoring	_____	_____
_____ Frequent Heavy Snoring Which Affects the Sleep of Others	_____	_____
_____ Gasping when Waking Up	_____	_____
_____ Nighttime Choking Spells	_____	_____
_____ Significant Daytime Drowsiness	_____	_____
_____ Sleepy while Driving	_____	_____
_____ Witnessed Apneic Events	_____	_____
TMD / PAIN COMPLAINTS	_____	_____
_____ Facial Pain	_____	_____
_____ Headaches	_____	_____

Number	Frequency	Intensity
<i>#1 = the most severe symptom</i>	1-4	1-10
_____ Jaw Clicking	_____	_____
_____ Jaw Locking	_____	_____
_____ Jaw Pain	_____	_____
_____ Limited Mouth Opening	_____	_____
_____ Migraines	_____	_____
_____ Morning Head Pain	_____	_____
_____ Morning Hoarseness	_____	_____
_____ Neck Pain	_____	_____
_____ Nocturnal Teeth Grinding	_____	_____
_____ Pain when Chewing	_____	_____
_____ Ringing in the Ears	_____	_____
_____ Dizziness	_____	_____

Other - Write in:

Patient Signature _____

Date _____

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center? Yes No

Sleep Center Name _____
and Location _____

Sleep Study Date _____

FOR OFFICE USE ONLY		<input type="checkbox"/> mild													
The evaluation confirmed a diagnosis of	<input type="checkbox"/> moderate	obstructive sleep apnea													
	<input type="checkbox"/> severe														
The evaluation showed															
<table border="1"> <thead> <tr> <th></th> <th><i>during REM</i></th> <th><i>Supine</i></th> <th><i>Side</i></th> </tr> </thead> <tbody> <tr> <td>an RDI of _____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>an AHI of _____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>					<i>during REM</i>	<i>Supine</i>	<i>Side</i>	an RDI of _____	_____	_____	_____	an AHI of _____	_____	_____	_____
	<i>during REM</i>	<i>Supine</i>	<i>Side</i>												
an RDI of _____	_____	_____	_____												
an AHI of _____	_____	_____	_____												
a nadir SpO2 of _____ T90 _____															
Slow Wave Sleep	<input type="checkbox"/> Decreased	<input type="checkbox"/> None													
REM Sleep	<input type="checkbox"/> Decreased	<input type="checkbox"/> None													

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:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mask leaks | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobic associations |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Inability to get the mask to fit properly | <input type="checkbox"/> Yes <input type="checkbox"/> No An unconscious need to remove the CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Discomfort from headgear | <input type="checkbox"/> Yes <input type="checkbox"/> No Unable to sleep well |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Disturbed or interrupted sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Does not resolve symptoms |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Noise disturbing sleep and/or bed partner's sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Noisy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP restricted movements during sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Cumbersome |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP does not seem to be effective | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pressure on the upper lip causing tooth related problems | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Latex allergy | |

Other _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

Yes No Dieting

Yes No Weight loss

Yes No Surgery (Uvuloplasty)

Yes No Surgery (Uvulectomy)

Yes No Pillar procedure

Yes No Smoking cessation

Yes No CPAP

Yes No BiPap

Yes No Uvulectomy (but continues to have symptoms)

Yes No Uvuloplasty (but continues to have symptoms)

_____ Custom Item:
(Choose ONE from below)

_____ Custom Item:
(Choose ONE from below)

Yes No The patient will consider oral appliance therapy and will call to schedule an appointment to proceed if he wishes to pursue treatment

Other _____

THE EPWORTH SLEEPINESS SCALE

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

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (i.e. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopping for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____ (Add columns 0-3)

Patient Signature _____

Date _____

Page 3

FATIGUE SCALE

During the past week:

No <<

>> Yes

	1	2	3	4	5	6	7
I felt fatigued and had less motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and did not desire to exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigue that interfered with my physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which caused me frequent problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which prevented sustained physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and couldn't carry out certain duties and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue was among my three most disabling symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interfered with my work, family or social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____