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

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 _____

Medical History Questionnaire

NAME: _____ FORM DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____

Allergens

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

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			

Medical History

Significant	Medical Condition	Current / Never / Past	Date / Note	Significant	Medical Condition	Current / Never / Past	Date / Note
	Diabetes				Mood disorder		
	Difficulty sleeping				Multiple sclerosis		
	Dizziness				Muscular dystrophy		
	Emphysema				Nasal allergies		
	Epilepsy				Neuralgia		
	Fibromyalgia				Osteoarthritis		
	Glaucoma				Osteoporosis		
	Gout				Parkinson's disease		
	Heart attack				Prior orthodontic treatment		
	Heart murmur				Psychiatric care		
	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		
	Ischemic heart disease (reduced blood supply)				Thyroid disorder		
	Kidney problems				Tuberculosis		
	Liver disease				Tumors		
	Meniere's disease				Urinary disorders		
	Mitral valve prolapse						

Other

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

Confidential Medical History

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

Surgical Operations

Appendectomy	Hernia repair	Tonsillectomy
Back	Lung	Uvulectomy
Ear	Nasal	Periodontal
Gallbladder	Thyroid	Knee Replacement/Hip Replacement
Heart		

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

I authorize the release of a full report of examination findings, diagnosis, treatment program etc.. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: Date:

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

Patient Signature: Date:

Sleep Consultation

NAME: _____ CURRENT DATE: ___/___/____

DATE OF BIRTH: ___/___/_____ MALE 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	☐ Gasping causing waking up
☐ Difficulty concentrating	☐ Insomnia
☐ Excessive daytime sleepiness	☐ Nighttime choking spells
☐ Fatigue	☐ Snoring which affects the sleep of others
☐ Forgetfulness	☐ Witnessed cessation of breathing
☐ Frequent snoring	
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

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 Do not Fill This out

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

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:

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
Noise disturbing sleep and/or bed partner's sleep	Claustrophobic associations	

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)

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

Sleep Aid Yes No

If yes, name the medication: [ ]

- Bruxism (grinding teeth)
- Dry mouth
- Excessive movements
- Gasping
- Restless legs
- Waking up and having difficulty returning to sleep
- Dreaming

[ ] Frequency of nocturnal urination (# of times)

[ ] Getting up <# of times> per night

Witnessed apneas are:

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

Sleep History

Wake

Sleepiness while driving Yes No

Risks Discussed Yes No

The patient:

Awakens unrefreshed

Naps
- naps daily
- never naps
- occasionally naps

Has morning headaches

Snoring is reported as:

Frequency
- seldom
- never
- daily
- often

Worse when sleeping on your back

Worse following alcohol late at night

Severity
- light
- moderate
- loud

Patient Signature

I authorize the release of a full report of examination findings. diagnosis. treatment program etc.. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: Date:

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

Patient Signature: Date: