Patient Registration

Please fill in completely

Name:_____ Gender: ☐ Male ☐ Female Date:_____

Address:_____

_

City:_____State:_____Zip:_____

Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

E-Mail address:_____ Preferred form of contact: _____

Birth date:_____Social Security Number:_____

Employer:_____

How did you hear about our office?_____

Present dentist:_____

Address:_____Phone:(___)_____

City:_____State:_____Zip:_____

Date of last visit:_____

Present physician:_____

Address:_____Phone(___)_____

City:_____State:_____ Zip:_____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

Health Insurance Information

Medical Insurance Company:_____

ID#:_____Group #:_____

Subscriber's Name:_____Subscriber's Social Security #:_____DOB:_____

Records release: I hereby authorize the Snoring and Sleep Apnea Dental Treatment Center to release my information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patient (or parent if minor)
Signature:_____Date:_____

Initial Evaluation Questionnaire

Date: _____/_____/_____ Code Number:_____
Mo. Day Year

Sex: □ 1 Male □ 2 Female

Date of Birth: _____/_____/_____ Age:_____
Mo. Day Year

Marital Status: □ 01 Single □ 05 Widowed
□ 02 Married □ 06 Divorced and remarried
□ 03 Divorced □ 07 Domestic partner
□ 04 Separated

Race: □ 1 Caucasian □ 3 Asian □ 5 Other (specifiy):_____
□ 2 African American □ 4 Hispanic

Is there usually a bed partner to observe your sleep?: □ 1 Yes □ 2 No

During the last week:	**Never**	**Rarely**	**Some-times**	**Often**
1. Have you snored or have you been told that you do?	□1	□2	□3	□4
2. Have you had choking or shortness of breath sensations at night?	□1	□2	□3	□4
3. Have you woken up during sleep?	□1	□2	□3	□4
4. Have you had morning fatigue or fogginess or woken up feeling unrefreshed?	□1	□2	□3	□4
5. Have you woken up with a headache?	□1	□2	□3	□4
6. Have you had chronic sleepiness, fatigue or weariness that you can't explain?	□1	□2	□3	□4
7. Have you fallen asleep during the day, particularly when not busy?	□1	□2	□3	□4
8. Have you fallen asleep reading or watching television?	□1	□2	□3	□4
9. Have you fallen asleep during the day against your will?	□1	□2	□3	□4
10. Have you had to pull off the road while driving due to sleepiness?	□1	□2	□3	□4
11. Have you been more irritable and short-tempered?	□1	□2	□3	□4
12. Have you felt your memory and/or intellect is impaired?	□1 Yes	□2 No		
13. Have you been told that you stop breathing while asleep?	□1 Yes	□2 No		

Questionnaire for Sleep Apnea and/or Snoring

(use back if more spaces is needed)

Name:_____Date:_____

1. How long have you been aware of your snoring? _____
2. Has it caused problems for relatives or friends? _____
3. Have you been told your breathing stops while asleep? _____
4. Have you been told you move around a lot while asleep? _____
5. About how many times per night do you wake up? _____
6. Do you have any difficulty falling asleep at night? _____
7. How many hours of sleep per night do you get? _____
8. Do you most often wake up feeling refreshed? _____
9. Do you often wake up with a headache? _____
10. Will a small amount of alcohol give you a hangover? _____
11. Do you feel sleepy during the day? □ frequently □ occasionally □ seldom □ never
12. What other doctors have you seen about your snoring or sleep apnea? _____
13. Have you had a sleep lab study? □Yes □No
14. Do you have difficulty breathing through your nose? □ Yes □ No
15. Have you gained weight recently? □Yes □No
    About how much? _____
16. Present body weight:_____ Height:_____ft._____inches
17. What professional advice or treatment have you received about your snoring or sleep apnea?
    _____
    _____

Signataure:_____Date:_____

The Epworth Sleepiness Scale

Name: _____

Today's Date: _____

Your Age (years): _____

Your Sex: ___ Male ___ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the ***most appropriate number*** for each situation.

0 = would ***never*** doze.

1 = ***slight*** chance of dozing

2 = ***moderate*** chance of dozing

3 = ***high*** chance of dozing.

Situation:	**Chance of dozing**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater or 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

Thank you for your cooperation !

Personal Medical, Family and Social History with Review of Systems

Name:_____Date:_____

Do you have or have you had any pain in any of the following areas?
[Please circle any that apply] Jaw Ear Face Neck Teeth Headaches
Other:_____

Does your jaw make any of the following noises?
[Please circle any that apply] Clicking Popping Rubbing Grinding Crunching
Other:_____

Have you received treatment for any TMJ, head, or neck symptoms? Yes No
When was your last dental visit?_____
Have you been told that you have periodontal (gum) disease? Yes No
Do you have any existing problems with your teeth? Yes No
Describe:_____
Is any dental treatment planned? Yes No

Personal Medical History

General

Change in Appetite	Y	N
Fever	Y	N
General Weakness	Y	N
Marked Weight Change	Y	N
Night Sweats	Y	N
Polyuria (frequent urination)	Y	N
Recent Trauma or Injury	Y	N
Unusual Weakness	Y	N
Chronic Fatigue Syndrome	Y	N
Hepatitis	Y	N
Tumors/cancer	Y	N
HIV/AIDS	Y	N

Allergies

Anaphalyctic reaction	Y	N
Dairy	Y	N
Dust	Y	N
Excessive sneezing	Y	N
Hay Fever	Y	N
Latex	Y	N
Penicillin	Y	N
Sulpha drugs	Y	N
Wheat	Y	N

Neurological

Confusion	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Muscle weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Tremor	Y	N
Alzheimer's Disease	Y	N
Multiple Sclerosis (MS)	Y	N

Skin

Acne	Y	N
Frequent bleeding	Y	N
Bruising	Y	N
Eczema	Y	N
Itch	Y	N
Lesions	Y	N
Psoriasis	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Changes	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in hearing	Y	N
Change in Smell	Y	N
Dysphagia (difficulty swallowing)	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hearing loss	Y	N
Hoarseness	Y	N
Nasal Discharge	Y	N

EENT- cont. Y N
Sinus problems…… Y N
Tinnitus (ringing in ears)…… Y N
Visual Changes…… Y N

Cardiovascular Y N
Coronary Artery Disease…… Y N
Chest pain…… Y N
Congstive Heart Failure…… Y N
Heart Attack…… Y N
Heart Murmur…… Y N
High Blood Pressure…… Y N
High Cholesterol…… Y N
Irregular Heart Beat…… Y N
Tachycardia (rapid heart beat)…… Y N

Respiratory
Asthma…… Y N
Bronchitis…… Y N
Chest pressure…… Y N
Colored sputum…… Y N
Congestion…… Y N
Cough…… Y N
Dyspnea (shortness of breath)…… Y N
Emphysema…… Y N
Hemoptysis (coughing up blood)…… Y N
Hypoventilation Syndrome…… Y N
Orthopnea (shortness of breath while supine)…… Y N
Pneumonia…… Y N
Pulmonary embolism…… Y N
Shortness of breath…… Y N
Tuberculosis…… Y N

Gastrointestinal
Black or bloody stool…… Y N
Constipation…… Y N
Diarrhea…… Y N
GERD…… Y N
Irritable Bowel Syndrome…… Y N
Stomach pain…… Y N
Ulcers…… Y N
Vomiting…… Y N

List any medications you are taking: Dosage

Nasal Obstruction…… Y N
Nose Bleeding…… Y N

Genitourinary
Frequent Urination…… Y N
Hematuria (blood in urine)…… Y N
Incontinence…… Y N
Kidney Infections…… Y N
Kidney Stones…… Y N
Kidney Disease…… Y N
Prostate problems…… Y N
Cervical/Uterine/Ovarian/Breast Cancer…… Y N
Currently pregnant?…… Y N

Psychiatric
ADD/ADHD…… Y N
Anxiety…… Y N
Autism…… Y N
Depression…… Y N
Disorientation…… Y N
Excess Stress…… Y N
Hallucination…… Y N
Memory problems…… Y N
Eating Disorders…… Y N
Chemical Dependency…… Y N

Musculoskeletal
Back pain…… Y N
Fibromyalgia…… Y N
Joint pain…… Y N
Limited range of motion…… Y N
Muscle Atrophy…… Y N
Muscle pain…… Y N

Social History

Do you smoke? N Y_____ packs a day
Do you consume alcoholic beverages?
_____ Drinks per day/week/month

List any surgeries you have had:

List any Vitamins/Supplements you are taking:

I certify that the above information is correct to the best of my knowledge.

Patient signature:_____ Date:_____
[Patient or guardiang, if patient is a minor]

DDS signature:_____

Bed Partner/Witness Screening Questionaire: Obstructive Sleep Apnea

Name:_____

Person completing form:_____ Date:____/____/____

Please answer the following questions as they pertain to your bed partner in the past month.

1. While sleeping, does your partner:

Snore more than half the time?.....Y N DK
Always snore?.....Y N DK
Snore loudly?.....Y N DK
Have "heavy" or loud breathing?.....Y N DK
Have trouble breathing, or struggle to breathe?.....Y N DK

2. Have you ever seen your partner stop breathing during the night?.....Y N DK

3. Does your bed partner ever have snorting or choking episodes during the night?.....Y N DK

4. Does your partner:

Tend to breathe through the mouth?.....…… ……...Y N DK
Have a dry mouth on waking up in the morning?…… .Y N DK
Occasionally wet the bed?.....Y N DK

5. Have you ever experienced your partner:

Grinding their teeth during the night?.....Y N DK
Have twitching or kicking of their legs or arms?.....Y N DK

6. Does your partner:

Wake up feeling unrefreshed in the morning?.....Y N DK
Have a problem with sleepiness during the day?.....Y N DK

7. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day?.....Y N DK

8. Is it hard to wake your partner up in the morning?.....Y N DK

9. Does your partner wake up with headaches in the morning?.....Y N DK

10. Is your partner overweight?.....Y N DK

SNORING & SLEEP APNEA
DENTAL TREATMENT CENTER

7225 Ohms Lane Suite 180 Edina, MN 55439
P 952.345.0290 F 952.920.0105
info@snoringandsleepapneamn.com
www.snoringandsleepapneamn.com

Billing and Insurance Policy

The Snoring and Sleep Apnea Dental Treatment Center would like to thank you for choosing us for your care. We are committed to you and your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

In-network Providers

We are providers for most Blue Cross Blue Shield,Medica and Preferred One plans, and our agreement with these insurance carriers states that the designated co-pay is due at the time of service.

Out-of-network Providers

If you have coverage through any other insurance carriers, full payment will be due at the time of service. We will send all claims to your insurance company and will assist you in getting reimbursement. Many insurance plans require a referral from your physician in order to get coverage, so you may need to contact your medical clinic to have the referral sent to our office.

You may choose to contact your insurance company prior to treatment to confirm the amount or percent of coverage for your care in this office. Then you will know your financial responsibility before we begin treatment.

I have read, understand and agree to follow the policies as stated above.

Signature _____ Date _____