Patient Information

Date:____/_____/_____

Name:_____Date of Birth_____/_____/_____
Last First Middle

Home Address:_____City:_____State:_____Zip:_____

Mailing Address (if different):_____City:_____State:_____Zip:_____

Phone numbers: Home:_____Cell:_____Work:_____Ext:_____

Email address:_____

Gender: M F Marital Status: ___Single ___Married ___Divorced ___Widowed

Emergency Contact: Name_____Phone_____Relationship_____

Medical Insurance Information (Please be prepared to present your card(s) and ID)

Primary Co:_____ID #_____Group #_____

Name of Primary Person Insured_____dob___/___/_____Relationship_____

Secondary Co:_____ID #_____Group #_____

Medical History

Primary Care Dr:_____City:_____State_____

Specialist Dr:_____City:_____State_____

Dentist:_____ City:_____State_____

Indicate any of the following conditions you may have experienced (Please circle Y or N for EACH item)

Y N	Acid Reflux (GERD)	Y N	Chemotherapy	Y N	Migraine Headache
Y N	Allergies (environmental)	Y N	Chronic Pain	Y N	Morning Headache
Y N	Angina	Y N	COPD	Y N	Psychiatric Treatment
Y N	Pacemaker	Y N	Depression	Y N	Radiation Therapy
Y N	Asthma	Y N	Diabetes	Y N	Stroke
Y N	Blood Pressure (high)	Y N	Epilepsy/Seizures	Y N	Thyroid Disorder
Y N	Blood Pressure (low)	Y N	Latex Allergy	Y N	Tuberculosis
Y N	Cancer	Y N	Lung Disease	Other Significant Health Concern:	
Y N	Chemical Dependency	Y N	Heart Disease	_____	

List all current Prescription Medications and the reason you are taking them

Medication_____for_____ Medication_____for_____

Medication_____for_____ Medication_____for_____

Medication_____for_____ Medication_____for_____

Are you allergic to any medication? Y N Which Ones?_____

Do you currently smoke? Y N Do you use oral tobacco? Y N Have you had orthodontic

Do you use alcohol? Y N Do you use sedatives? Y N treatment? Y N When?_____

Sleep Apnea Questionnaire and Affidavit of CPAP Intolerance

Have you ever had past TMJ problems? Y N Do you have TMJ pain/problems now? Y N
Have you been diagnosed with sleep apnea? Y N
If so, approximately when was the sleep study performed? Date_____
What is the name and location of the sleep center you used? _____City_____
Were you prescribed a CPAP machine? Y N If so, are you using it? Y N
Have you tried other apnea therapies (surgery, wt. loss, etc) Y N list:_____

If you cannot tolerate CPAP or choose not to use it, please indicate the reason(s) why:

___Mask leaks ___Mask does not fit ___Discomfort from mask/straps
___Noise disturbs partner ___CPAP restricts movement ___CPAP seems ineffective
___Pressure/tooth problems ___Latex allergy ___Claustrophobia
___History of surgery/injury to head or neck area ___PTSD ___Small children living in home
___Unconscious need to remove CPAP ___Other_____

Epworth Sleepiness Scale

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. Using the following scale, circle 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

Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting, inactive, in a public place (theater, meeting, etc)	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
				Total _____

I believe the information provided above to be complete and accurate. I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician, and I authorize the release of any medical information to insurance companies for legal documentation necessary to process claims.

Patient Signature: _____ Date: _____/_____/_____
Print Name: _____