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 ____________________

Version: SLPQV2

Sleep Consultation

OFFICE USE
Patient ID: ___________

NAME: ______________________________________ TODAY'S DATE ____________________
First *Middle Initital* *Last*

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 *#1 = the most severe symptom*		Frequency 1-4	Intensity 1-10
	TMD / PAIN COMPLAINTS	____	____
____	Difficulty Swallowing	____	____
____	Dizziness	____	____
____	Facial Pain	____	____
____	Headaches	____	____
____	Jaw Clicking	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Migraines	____	____
____	Morning Head Pain	____	____
____	Morning Hoarseness	____	____
____	Neck Pain	____	____
____	Nocturnal Teeth Grinding	____	____
____	Pain when Chewing	____	____

Other - Write in:

____	____________________	____	____
____	____________________	____	____
____	____________________	____	____

Number *#1 = the most severe symptom*		Frequency 1-4	Intensity 1-10
____	Ringing in the Ears	____	____
	SLEEP BREATHING COMPLAINTS	____	____
____	CPAP Intolerance	____	____
____	Difficulty Falling Asleep	____	____
____	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	____	____
____	____________________	____	____
____	____________________	____	____
____	____________________	____	____

Patient Signature ______________________________ Date ____________________

THE EPWORTH SLEEPINESS SCALE

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

✓ **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	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. 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 quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: __________ *(Add columns 0-3)*

FATIGUE SCALE

During the past week:	**No << 1**	**2**	**3**	**4**	**5**	**6**	**>> Yes 7**
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: _____

Patient Signature ______________________________ Date ____________________

Berlin Questionnaire Sleep Evaluation

category 1

1. Complete the following:

   Height ________ Weight ________

2. Do you snore?
   - ☐ yes
   - ☐ no
   - ☐ don't know

If you snore: *(Answer questions 3-6)*

3. Your snoring is?
   - ☐ slightly louder than breathing
   - ☐ as loud as talking
   - ☐ louder than talking
   - ☐ very loud. Can be heard in adjacent rooms

4. How often do you snore?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

5. Has your snoring ever bothered other people?
   - ☐ yes
   - ☐ no

6. Has anyone noticed that you quit breathing during your sleep?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

category 2

7. How often do you feel tired or fatigued after your sleep?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a behicle?
   - ☐ yes
   - ☐ no

   If yes, how often does it occur?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

category 3

10. Do you have high blood pressure?
    - ☐ yes
    - ☐ no
    - ☐ don't know

(For office use)

Scoring Questions: Any answer within the box is a positive response

Scoring categories

Category 1 is positive with 2 or more positive responses to questions 2-6 ☐

Category 2 is positive with 2 or more positive responses to questions 7-9 ☐

Category 3 is positive with 1 positive response and/or a BMI > 30 ☐ *(BMI = Body Mass Index)*

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature ______________________ Date ____________

SLEEP STUDIES

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

Sleep Center Name and Location ______________________________

____

Sleep Study Date ______________________________

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ☐ mild ☐ moderate ☐ severe obstructive sleep apnea

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	______	______	______	______
an AHI of	______	______	______	______

a nadir SpO2 of ______ T90 ______

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:

__Yes __No Mask leaks
__Yes __No Inability to get the mask to fit properly
__Yes __No Discomfort from headgear
__Yes __No Disturbed or interrupted sleep
__Yes __No Noise disturbing sleep and/or bed partner's sleep
__Yes __No CPAP restricted movements during sleep
__Yes __No CPAP does not seem to be effective
__Yes __No Pressure on the upper lip causing tooth related problems
__Yes __No Latex allergy

__Yes __No Claustrophobic associations
__Yes __No An unconscious need to remove the CPAP
__Yes __No Unable to sleep well
__Yes __No Does not resolve symptoms
__Yes __No Noisy
__Yes __No Cumbersome

Other ______________________ ______________________ ______________________

Patient Signature ______________________ Date ______________

SLEEP HISTORY

Previous Diagnosis

☐ Yes ☐ No Have you been previously diagnosed with Obstructive Sleep Apnea?

If Yes, how long ago was it? ________ ☐ Years ago ☐ Months ago ☐ Days ago
number

Snoring is reported as:

______ Frequency
______ (Choose ONE from below)
______ seldom
______ never
daily
often
______ Severity
______ (Choose ONE from below)
______ light to moderate
______ moderate to loud
______ light
moderate
loud
__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Sleep:

__Yes __No Bruxism
__Yes __No Dry mouth
__Yes __No Excessive movements
__Yes __No Gasping
__________ Getting up <number of times> per night
__Yes __No Hypnagogic Hallucinations
__Yes __No Reading or watching TV before sleeping
__Yes __No Restless legs
__Yes __No Waking up and having difficulty returning to sleep
__Yes __No Dreaming
__________ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Wake

__Yes __No Awakens unrefreshed
__Yes __No Has morning headaches
__Yes __No Has problematic daytime sleepiness
______ Naps
______ (Choose ONE from below)
______ naps daily
______ never naps
occasionally naps
rarely naps

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 ______________

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

___Yes	___ No	Cancer	___ Yes	___ No	Obesity
___Yes	___ No	Heart disease	___ Yes	___ No	Thyroid trouble
___Yes	___ No	Diabetes	___ Yes	___ No	Father snores
___Yes	___ No	High blood pressure	___ Yes	___ No	Mother snores
___Yes	___ No	Stroke	___ Yes	___ No	Father has sleep apnea
___Yes	___ No	Sleep disorder	___ Yes	___ No	Mother has sleep apnea

Other ____________________ ____________________ ____________________

SOCIAL HISTORY

Tobacco Use: Cigarettes ☐ Never Smoked ☐ Current Smoker # of packs/day ___ # of years ______ ☐ Quit When did you quit? ________________

Other Tobacco: ☐ Pipe ☐ Snuff ☐ Cigar ☐ 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: ☐ Yes ☐ No Regular Exercise

I authorize the release of a full report 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 ____________________

Patient Signature ____ **Date**______________________

OFFICE USE
Patient ID: __________

Medical History Questionnaire

NAME______________________________________. TODAY'S DATE:______________.
First Middle Initial Last 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 as completely and honestly as possible. Please sign each page.

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

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other ____________________ ____________________ ____________________

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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					Immune system disorder				
Acid reflux					Hepatitis				
Adenoids removed					Injury to face				
Anemia					Injury to mouth				
Arteriosclerosis					Injury to neck				
Arthritis					Injury to teeth				
Asthma					Insomnia				
Autoimmune disorder					Intestinal disorders				
Bleeding easily					Jaw joint surgery				
Blood pressure - high					Kidney problems				
Blood pressure - low					Liver disease				
Bruising easily					Low energy				
Cancer					Lung disease				
Chemotherapy					Meniere's disease				
Chest pains					Multiple sclerosis				
Chronic cough					Muscular dystrophy				
Chronic fatigue					Needing extra pillows to help breathing at night				
Chronic pain					Nose bleeds often				
Chronically tired					Osteoarthritis				
Cold hands and feet					Osteoporosis				
Cold sores					Pacemaker				

Patient Signature ______________________________ Date____________________

Medical condition	Never	Current	Past	If past, enter date	Medical condition	Never	Current	Past	If past, enter date
COPD					Parkinson's disease				
Depression					Polio				
Diabetes					Poor circulation				
Difficulty concentrating					Prior orthodontic treatment				
Difficulty sleeping					Prostate problems				
Dizziness					Psychiatric care				
Emphysema					Radiation treatment				
Epilepsy					Reactions to lead/mercury				
Fainting spells					Reduced sex desire				
Fast pulse					Rheumatic fever				
Fatigue easily					Rheumatoid arthritis				
Fibromyalgia					Scarlet fever				
Gall bladder problems					Scoliosis				
General anesthesia					Shortness of breath				
Glaucoma					Sinus problems				
Hearing impaired					Sleep apnea				
Heart attack					Speech difficulties				
Heartburn					Stroke				
Heart disease					Swallowing problems				
Heart murmur					Thyroid disorder				
Heart pacemaker					Tonsils removed				
Heart palpitations					Tuberculosis				
Heart problems					Tumors				
Heart valve replacement					Ulcers				
Hemophilia					Wisdom teeth (third molar extraction				
Hypoglycemia									

Other	Current	Past	If past, enter date	Other	Current	Past	If past, enter date

ADDITIONAL MEDICAL HISTORY ITEMS

	Never	Current	Past	If past, enter date		Never	Current	Past	If past, enter date
Recreational drugs					HIV/AIDS				

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y☐ N☐ Appendectomy
Y☐ N☐ Back
Y☐ N☐ Ear
Y☐ N☐ Gallbladder
Y☐ N☐ Heart
Y☐ N☐ Hernia repair
Y☐ N☐ Lung
Y☐ N☐ Nasal
Y☐ N☐ Thyroid
Y☐ N☐ Tonsillectomy
Y☐ N☐ Uvulectomy
Y☐ N☐ Periodontal

Other ______________________ ______________________ ______________________

______________________ ______________________ ______________________

Patient Signature ____ Date________________