Sleep & TMD Patient Registration

First Name: _____ Last Name: _____ Middle Initial: ___
Other Dentists, if applicable: _____Phone: _____
Physician Name: _____
Address: _____
Phone: _____
Whom may we thank for referring you to our practice? _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ___
Street Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ ext_____ Cell: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date: _____ Social Sec. # _____ Driver License: _____
Email: _____ Spouse Name: _____
Occupation: _____ Employer Name: _____

Employment Status ☐ Full Time ☐ Part Time ☐ Retired Height: ____Feet ___Inches

Student Status ☐ Full Time ☐ Part Time Weight: _____
Preferred Dentist: _____ Preferred Pharmacy: _____

Primary Medical Insurance Information

First Name of Insured: _____ Last Name: _____ Middle Initial: ___

Policy/Group Number: _____ Relationship to Insured: ☐ Self ☐ Spouse

Insurance ID Number: _____ ☐ Child ☐ Other
Insured Soc.Sec. Number: _____ Insured Birth Date: _____
Employer: _____
Insured Address if different than patient's Insur. Company: _____
Street Address: _____ Street Address: _____
City, State, Zip: _____ City, State, Zip: _____
Telephone: _____

Secondary Medical Insurance Information

First Name of Insured: _____ Last Name: _____ Middle Initial: ___

Policy/Group Number: _____ Relationship to Insured: ☐ Self ☐ Spouse

Insurance ID Number: _____ ☐ Child ☐ Other
Insured Soc.Sec. Number: _____ Insured Birth Date: _____
Employer: _____
Insured Address if different than patient's Insur. Company: _____
Street Address: _____ Street Address: _____
City, State, Zip: _____ City, State, Zip: _____
Telephone: _____

Medical History Questionnaire

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a 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:

☐ Antibiotics
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetics
☐ Metals
☐ Penicillin
☐ Plastic
☐ Sedatives
☐ Sleeping Pills
☐ Sulfa drugs
☐ Other _____
☐ Other _____

List any medications currently being taken:

Medication Name	Dosage/Frequency	Reason

Medical History: (Please indicate dates on items marked past)

Medical condition	Never	Current	Past	If past, enter date
Acid Reflux	☐	☐	☐	_____
Adenoids Removed	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Arteriosclerosis	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____
Blood pressure – High	☐	☐	☐	_____
Blood pressure – Low	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic cough	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____
Cold hands and feet	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
COPD	☐	☐	☐	_____
Current pregnancy	☐	☐	☐	_____

Depression	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Difficulty concentrating	☐	☐	☐	_____
Dizziness	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Excessive thirst	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____
Fluid retention	☐	☐	☐	_____
Frequent cough	☐	☐	☐	_____
Frequent illnesses	☐	☐	☐	_____
Frequent stressful situations	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Gout	☐	☐	☐	_____
Hay fever	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Headaches	☐	☐	☐	_____
Hearing impaired	☐	☐	☐	_____
Heart attack	☐	☐	☐	_____
Heart disorder	☐	☐	☐	_____
Heart murmur	☐	☐	☐	_____
Heart pacemaker	☐	☐	☐	_____
Heart palpitations	☐	☐	☐	_____
Heart valve replacement	☐	☐	☐	_____
Hemophilia	☐	☐	☐	_____
Hepatitis	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Hypoglycemia	☐	☐	☐	_____
Immune system disorder	☐	☐	☐	_____
Injury to face	☐	☐	☐	_____
Injury to mouth	☐	☐	☐	_____
Injury to neck	☐	☐	☐	_____
Injury to teeth	☐	☐	☐	_____
Insomnia	☐	☐	☐	_____
Intestinal disorders	☐	☐	☐	_____
Jaw joint surgery	☐	☐	☐	_____
Kidney problems	☐	☐	☐	_____
Liver disease	☐	☐	☐	_____
Meniere's disease	☐	☐	☐	_____
Menstrual cramps	☐	☐	☐	_____
Multiple sclerosis	☐	☐	☐	_____
Muscle aches	☐	☐	☐	_____
Muscle shaking (tremors)	☐	☐	☐	_____
Muscle spasms or cramps	☐	☐	☐	_____
Muscular dystrophy	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Ovarian cysts	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Parkinson's disease	☐	☐	☐	_____
Poor circulation	☐	☐	☐	_____
Prior orthodontic treatment	☐	☐	☐	_____
Psychiatric care	☐	☐	☐	_____
Radiation treatment	☐	☐	☐	_____
Rheumatic fever	☐	☐	☐	_____
Rheumatoid arthritis	☐	☐	☐	_____
Scarlet fever	☐	☐	☐	_____
Scoliosis	☐	☐	☐	_____
Shortness of breath	☐	☐	☐	_____
Sinus problems	☐	☐	☐	_____
Skin disorder	☐	☐	☐	_____
Sleep apnea	☐	☐	☐	_____
Slow healing sores	☐	☐	☐	_____
Speech difficulties	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Swelling in ankles or feet	☐	☐	☐	_____
Swollen, stiff or painful joints	☐	☐	☐	_____
Tendency for ear infections	☐	☐	☐	_____
Tendency for frequent colds	☐	☐	☐	_____
Tendency for sore throats	☐	☐	☐	_____
Thyroid disorder	☐	☐	☐	_____
Tonsils Removed	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Urinary disorders	☐	☐	☐	_____
Wisdom teeth extraction	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

Additional Medical History Items: (Please indicate dates on items marked past)

Recreational drugs	☐	☐	☐	_____	HIV/AIDS	☐	☐	☐	_____

List Any Surgical Operations You Have Had:

___ Appendectomy
___ Back
___ Ear
___ Gallbladder
___ Heart
___ Lung
___ Nasal
___ Thyroid
___ Tonsillectomy
___ Uvulectomy
___ Periodontal
___ Other
___ Other
___ NO SURGERIES

Family History Has any member of your family had (parent, sibling or grandparent):

___ Cancer
___ Heart disease
___ Diabetes
___ High blood pressure
___ Stroke
___ Sleep disorder
___ Obesity
___ Thyroid disorder
___ Father snores
___ Mother snores
___ Father has sleep apnea
___ Mother has sleep apnea
___ Other: _____
___ None of the above

Social History:

Cigarettes: ☐ Never smoked ☐ Current Smoker # packs/day ____ # of years ____ ☐ Quit When did you quit? _____

Other Tobacco: ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew

Alcohol Use: ☐ Yes ☐ No If yes, # of drinks per week: _____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day: _____

Regular Exercise: ☐ Yes ☐ No

Sleep Hygiene:

To fall asleep do you: ☐ Read ☐ Watch TV ☐ Use PC/ Ipad/ cell phone
☐ Take sleep aids / explain _____
☐ Use ___ # of pillows under my ☐ head only ☐head, shoulders ☐ head, shoulders, back

Do you sleep on your (check all that apply) : ☐ back ☐ R side ☐ L side ☐ Stomach

Date of Most Recent Complete Blood Work: _____

Were you made aware of any levels not within normal limits: ☐ Yes ☐ No

If so, have those deficient levels been corrected? ☐ Yes ☐ No

And how? Medications prescribed by physician: _____

Vitamin/Mineral supplements: _____

Other recommended therapies: _____

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

Patient Signature _____ Date _____

Patient Name (Printed) _____

Sleep Apnea/ TMD Patient Report

Patient's Chief Complaint / Narrative:

Please indicate the chief complaints for which you are seeking treatment. For the symptoms you check, please specify the severity of those symptoms on a scale of 1(slightly bothersome) to 5 (very bothersome).

TMD

☐ Difficulty Swallowing	1 2 3 4 5
☐ Dizziness	1 2 3 4 5
☐ Facial Pain	1 2 3 4 5
☐ Headaches	1 2 3 4 5
☐ Jaw Clicking	1 2 3 4 5
☐ Jaw Locking	1 2 3 4 5
☐ Jaw Pain	1 2 3 4 5
☐ Limited Mouth Opening	1 2 3 4 5
☐ Migraines	1 2 3 4 5
☐ Morning Hoarseness	1 2 3 4 5
☐ Neck Pain	1 2 3 4 5
☐ Nocturnal Teeth Grinding	1 2 3 4 5
☐ Pain when Chewing	1 2 3 4 5

Sleep Breathing Complaints

☐ CPAP Intolerance	1 2 3 4 5
☐ Difficulty Falling Asleep	1 2 3 4 5
☐ Difficulty Staying Asleep	1 2 3 4 5
☐ Fatigue	1 2 3 4 5
☐ Frequent Heavy Snoring	1 2 3 4 5
☐ Frequent Heavy Snoring which affects the sleep of others	1 2 3 4 5
☐ Frequent Nighttime Urination	1 2 3 4 5
☐ Gasping when Waking up	1 2 3 4 5
☐ Morning Headaches	1 2 3 4 5
☐ Nighttime Choking Spells	1 2 3 4 5
☐ Excessive Daytime Sleepiness	1 2 3 4 5
☐ Sleepy while Driving	1 2 3 4 5
☐ Witnessed Apneic Events	1 2 3 4 5

*Please describe in your own words your **previous attempts to treat your obstructive sleep apnea or TMD and to what extent you are still using any of these treatments**.*

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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

Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 6 or greater indicates the possibility of a sleep breathing disorder.

Patient Signature _____ Date _____

Patient Name (Printed) _____

Assignment of Benefits and Medical Information Release

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. Additionally "I authorize the release of any holder of Medical Information about me to release to Dr. Steven Danney, my physician(s), caregiver, CMS or its agents" and to insurance companies or for legal documentation to process claims. I authorize assignment of insurance benefits to S.Danney Dental Group Sleep Medicine, Inc. (dba Sleep Apnea San Diego) for medical services and/or supplies furnished to me by Dr. Steven Danney. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Patient Signature _____ Date _____

Patient Name (Printed) _____

AFFIDAVIT FOR INTOLERANCE TO CPAP

NAME_____

I have attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons(s):

_____Mask leaks

_____Unable to get the mask to fit properly

_____Mask uncomfortable / Device uncomfortable

_____Unable to sleep comfortably

_____Noise disturbs my sleep and/or bed partner's sleep

_____Restricts movement during sleep

_____Does not seem to be effective

_____Straps / headgear cause discomfort

_____Pressure on the upper lip cause tooth related problems

_____Latex allergy

_____Claustrophobic associations

_____An unconscious need to remove CPAP

_____Other: _____

Because of my intolerance/inability to use CPAP, I wish to have an alternative method of treatment. That form of therapy is an Oral Sleep Appliance.

Signed_____

Date_____

Sleep Observer's Scale

(Bed Partner to complete)

_____ before oral appliance date: _____

_____ after oral appliance date: _____

Patient: _____ DOB: _____

Observer: _____ Relation: _____

0 = Never **1 = Infrequent** One night/week **2 = Frequent** 2-3 nights/week **3 = Most of the time** 4 or more nights/week

	Before OA	After OA
1 – Loud, disruptive snoring		
2 – Choking, gasping for air		
3 – Breathing stoppages		
4 – Twitching, kicking arms and/or legs		
5 – Snoring requiring separate bedroom		
6 – Falling asleep at inappropriate times, i.e., while driving		
TOTAL SCORE:		