NEW PATIENT FORMS – SLEEP APNEA

How did you hear about us? _____

PATIENT INFORMATION

Last Name	First Name	Date of Birth

Sex	Primary Phone #	Type of Phone	SS#
☐ Male ☐ Female ☐ Other		☐ Home ☐ Mobile ☐ Work	

Email Address	Preferred method(s) of communication	Address Line 1
	☐ Phone ☐ Text ☐ Email	

Address Line 2	City

State	ZIP	Marital Status
		☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMERGENCY CONTACTS

Emergency Contact Person	Relationship to Patient

Primary Phone #	Type of Phone	Email Address
	☐ Home ☐ Mobile ☐ Work	

INSURANCE POLICY INFORMATION

Do you have medical insurance?

☐ Yes ☐ No If "Yes", please enter your policy information below, beginning with your Primary Insurance Policy.

Primary Insurance Policy

Insurance Company	Policy #

Group #	Insurance Co. Phone #	Address Line 1

Address Line 2	City	State	ZIP

Policy Holder's Full Name	Relationship to Patient

Policy Holder's SS#	Date of Birth

Secondary Insurance Policy ☐ **Yes** ☐ **No**

Insurance Company	Policy #

Group #	Insurance Co. Phone #	Address Line 1

Address Line 2	City	State	ZIP

Policy Holder's Full Name	Relationship to Patient

Policy Holder's SS#	Date of Birth

MEDICAL HISTORY

Please check all that apply.

HEAD
- ☐ Trauma
- ☐ Other

EYES
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other

NOSE / SINUSES
- ☐ Allergic Rhinitis
- ☐ Sinus Infections
- ☐ Other

URINARY
- ☐ Kidney Disease
- ☐ Other

SKIN
- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Other

If "Other", please specify _____

CARDIOVASCULAR
- ☐ High Blood Pressure (HTN)
- ☐ Myocardial Infarction
- ☐ Afib
- ☐ Other

RESPIRATORY
- ☐ Asthma
- ☐ COPD
- ☐ OSA (Obstructive Sleep Apnea)
- ☐ Other

DIGESTIVE
- ☐ GERD
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Other

ENDOCRINE
- ☐ Hyperlipidemia
- ☐ Thyroid Disease
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Other

If "Other", please specify _____

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Other

ONCOLOGY/BLOOD DISORDERS
- ☐ Anemia
- ☐ Cancer
- ☐ Lyme Disease
- ☐ HIV
- ☐ Other

NEUROLOGIC
- ☐ Epilepsy
- ☐ Seizures
- ☐ Migraines
- ☐ Stroke
- ☐ TIA
- ☐ Other

PSYCHIATRIC
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Suicide Attempts
- ☐ Insomnia
- ☐ Other

If "Other", please specify _____

Are you allergic to any medications?

☐ No ☐ Yes _____

Are you pregnant or nursing? ☐ Yes ☐ No

Date of last physical exam _____

Are you currently taking any medications? ☐ Yes ☐ No

If "Yes", please list any current medications you are taking.

_____

_____

Please list your healthcare providers, beginning with your primary care physician.

Primary Care

_____

Additional Healthcare Providers

_____

_____

_____

_____

SURGICAL HISTORY

Please check all that apply.

- ☐ Nasal/Sinus Surgery
- ☐ Adenoidectomy/Tonsillectomy
- ☐ Cancer Surgery
- ☐ Back Surgery
- ☐ Hysterectomy
- ☐ Hip Replacement
- ☐ Spinal/Cervical Fusion
- ☐ Other

If "Other", please explain.

DENTAL HISTORY

Name of current Dental Provider

Date of last dental exam

Please check all that apply.

- ☐ Dental Implants
- ☐ Dentures
- ☐ Jaw Surgery
- ☐ Night Guard for teeth grinding
- ☐ Orthodontic (Braces) Treatment
- ☐ Wisdom Teeth Extracted
- ☐ Other _____

Dental work scheduled/in progress:

Major dental work:

Family History

- ☐ OSA (Obstructive Sleep Apnea)
- ☐ Loud Snoring
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ TMD

Social History

- ☐ Do you smoke?
- ☐ Do you drink alcohol?
- ☐ Do you use illicit drugs?
- ☐ Do you eat a healthy diet?
- ☐ Do you exercise regularly?

SLEEP APNEA HISTORY

Have you ever been diagnosed with Obstructive Sleep Apnea (OSA)? ☐ No ☐ Yes

If yes, please list the most recent sleep study.

Where?

When?

Do you have a sleep doctor? ☐ No ☐ Yes

Name

Prior/Current treatments

- ☐ Never had treatment
- ☐ Tried CPAP, but not using
- ☐ Tried Oral Appliance, but not using
- ☐ Surgical Procedures _____
- ☐ Currently using CPAP
- ☐ Currently using Sleep Appliance
- ☐ Other _____

Comments

Do you have any of the following symptoms or if you are currently being treated, prior to treatment?

- ☐ Snoring
- ☐ Unrefreshing sleep
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Has somebody told you that you stop breathing while sleeping
- ☐ Have difficulty breathing through your nose at night
- ☐ Currently experiencing or have a history of jaw pain/jaw clicking/jaw locking
- ☐ Heartburn at night
- ☐ Excessive day time sleepiness
- ☐ Do you ever wake up startled/gasping for air
- ☐ Wake up with a headache often
- ☐ Excessively tired on a regular basis

What would you like to accomplish with Oral Appliance Therapy?

_____

_____

_____

_____

The doctor will discuss Oral Appliance Therapy in detail with you and will answer your questions.
Do you have any specific concerns or questions that are very important to you?

_____

_____

_____

_____