Nelson Dental Sleep Medicine

Patient Information

Mr./Ms./Mrs./Dr. First Name: ________________ Last Name: ____________ MI: __

Home Phone: (____) ___________ Cell Phone: (___) ___________

Email Address: __________________________

Address: ____________________________________ City: ________________

State: _________ Zip: ________ Date of Birth (M/D/Y): _______________

Gender: Male / Female Social Security Number: _______________

Height: Feet ___ Inches___ Weight (lbs.): ____

Marital Status: ☐ Married ☐ Single ☐ Life Partner

Emergency Contact: ________________ Relationship: ________ Phone: _________

Referred By: ________________________

Health Insurance Information

Patient's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured: ______________________ Date of Birth: ___/___/_____

Insurance Company: ________________________ ID #: _________________

Group #: _______ Plan Name: ______________ Phone#: (___) __________

Secondary Insurance Information

Do you have secondary insurance?☐Yes☐No If **YES**, Please Complete.

Patient's Relationship to Primary Insured:☐Self ☐Spouse ☐Child ☐Other

Name of Insured: ______________________ Date of Birth: ___/___/_____

Insurance Company: ________________________ ID #: _________________

Group #: _______ Plan Name: ______________ Phone#: (___) _________

Medical Contacts

Dental Sleep Solutions coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list other medical providers.

Primary Care: ___________________________ Phone: __________________

ENT: __________________________________ Phone: __________________

Sleep Doctor: ___________________________ Phone: __________________

Dentist: _______________________________ Phone: __________________

Other MD: _____________________________ Phone: __________________

EPWORTH SLEEPINESS SCALE

Sitting and reading	_____	0 = Would never doze
Watching TV	_____	1 = Slight chances of dozing
Sitting inactive in a public place (theater)	_____	2 = Moderate chance of dozing
As a passenger for an hour without a break	_____	3 = High chance of dozing
Lying down in the afternoon to rest	_____	
Sitting and talking to someone	_____	
Sitting quietly after lunch without alcohol	_____	
In a car while stopped at a traffic light	_____	**Total:** _____

My snoring affects my relationship with my partner	_____	0 = Never
My snoring causes my partner to be irritable or tired	_____	1 = 1 night/week
My snoring requires us to sleep in separate rooms	_____	2 =2-3 nights/week
My snoring is loud	_____	3 = 4+ nights/week
My snoring affects people when I am sleeping away from home.	_____	**Total:** _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea: ________________________________.

Do you have other complaints?

- ☐Frequent snoring
- ☐Excessive daytime sleepiness
- ☐Difficulty falling asleep
- ☐Waking up gasping/choking
- ☐Morning headaches
- ☐Neck or facial pain
- ☐I have been told I stop breathing when I sleep
- ☐Difficulty maintaining sleep
- ☐Choking while sleeping
- ☐Feeling unrefreshed in the morning
- ☐Memory problems
- ☐Impotence
- ☐Nasal problems
- ☐Irritability or mood swings

Other: ________________________

Subjective Signs and Symptoms

Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)
Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)
Have you been told you snore? ☐Yes ☐No ☐Sometimes
Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)
How many times per night do you wake up? _______
On average, how many hours of sleep do you get per night? _____
How often do you awaken with headaches? Never/Rarely/Sometimes/Often/Everyday
Do you have a bed partner? ☐Yes ☐No ☐Sometimes
Do you sleep in the same room? ☐Yes ☐No
How many times per night does your bedtime partner notice you stop breathing?
☐Several Time Per Night ☐Once Per Night☐ Several Times a Week☐ Occasionally ☐Seldom ☐Never

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Have you ever had a sleep study? ☐Yes ☐No
If YES, where and when? ______________________ Date: ____________
Have you tried CPAP? ☐Yes ☐No
Are you currently using CPAP? ☐Yes ☐No
If YES, how many nights per week do you wear it? ____
When you wear your CPAP, what are your chief complaints about CPAP?

☐Mask leaks
☐An inability to get the mask to fit properly
☐Discomfort from the straps or headgear
☐Decrease sleep quality or interrupted sleep from the CPAP device
☐Noise from the device disrupting sleep and/or bedtime partner\'s sleep
☐CPAP restricted movements during sleep
☐CPAP does not solve my sleep problems (ineffective)
☐Device causes teeth or jaw problems
☐A Latex allergy
☐Device causing claustrophobia or panic attacks
☐An unconscious need to remove the CPAP at night
☐GI/ Stomach/Intestinal
☐The CPAP device irritated nasal passages
☐Inability to wear due to nasal problems
☐CPAP caused dry nose and/or mouth
☐The device caused eye irritation due to air leak

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Nelson Dental
Sleep Medicine

Are you currently wearing a dental device? ☐Yes ☐No
Have you previously tried a dental device? ☐Yes ☐No
If YES, was it Over the Counter (OTC)? ☐Yes ☐No
Was it fabricated by dentist? ☐Yes ☐No
If YES, who fabricated it? ______________
If applicable, please describe your previous dental device experience: __________
Have you ever had surgery for snoring or sleep apnea? ☐Yes ☐No
Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

Date: ________ Surgeon: __________________ Surgery: _________________
Date: ________ Surgeon: __________________ Surgery: _________________
Date: ________ Surgeon: __________________ Surgery: _________________

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring, apnea, and sleep quality.

____
____
____

Pre-Medication- Have you been told you should receive pre-medication before a dental procedure? ☐Yes ☐No
If YES, what medication(s) and why do you require it? ______________________
____

Allergens- Please list everything you are allergic to (for example: aspirin, latex, etc.): ____
Medications- Please list all medications you are currently taking: _____________
____
____

Medical History- Please list all medical diagnoses and surgeries from birth until now (from birth until now (for example: heart attack, high blood pressure, asthma, HIV, etc.): ____
____
____

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Dental History

How would you describe your dental health?	Excellent	Good	Fair	Poor
Have you ever had teeth extracted?	Yes	No		
Do you wear removable partial?	Yes	No		
Do you wear full dentures?	Yes	No		
Have you ever worn braces?	Yes	No		
Does your TMJ (jaw joint) click or pop?	Yes	No		
Have you ever had TMJ (jaw joint) surgery?	Yes	No		
Have you ever had gum problems?	Yes	No		
Have you ever had gum surgery?	Yes	No		
Do you have dry mouth?	Yes	No		
Have you ever had an injury to your head, face, neck, or mouth?			Yes	No
Are you planning to have dental work done in the near future?			Yes	No
Do you clench or grind your teeth?			Yes	No

If you answered YES to any question above, please briefly describe your answer here: ______________________________

Family History

Have genetic members of your family had: Heart Disease? ☐Yes ☐No
High Blood Pressure? ☐Yes ☐No Diabetes? ☐Yes ☐No

Have genetic members of your family been diagnosed or treated for sleep disorder? ☐Yes ☐No

How often do you consume alcohol within 2-3 hours of bedtime?
☐Daily ☐Occasionally ☐Rarely/Never

How often do you take sedatives within 2-3 hours of bedtime?
☐Daily ☐Occasionally ☐Rarely/Never

How often do you consume caffeine within 2-3 hours of bedtime?
☐Daily ☐Occasionally ☐Rarely/Never

Do you smoke? ☐Yes ☐No If YES, how many packs per day? ___
Do you use chewing tobacco? ☐Yes ☐No If YES, how many times per day? ___

Patient Signature

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.

Patient Signature: ______________________ Date: ____________

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