

**NEW PATIENT INFORMATION**

Date: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Home PH: \_\_\_\_\_ Cell PH: \_\_\_\_\_ Work PH: \_\_\_\_\_

**Medical Insurance Information**

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Member #: \_\_\_\_\_

Group #: \_\_\_\_\_ Plan #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_ Referred to our office by: \_\_\_\_\_

**Dental Insurance Information**

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Member #: \_\_\_\_\_

Group #: \_\_\_\_\_ Plan #: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

**MEDICAL HISTORY**

Are you currently under a physician's care? Y/N If yes, why? \_\_\_\_\_

Please check any of the following that apply:

- |                                      |   |   |   |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Bleeding Gums      | <input type="checkbox"/> Tonsils/Adenoids Removed | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Fainting/Dizziness       | <input type="checkbox"/> Eating Disorder      |
| <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> HIV/AIDS Positive        | <input type="checkbox"/> Heart Trouble        |
| <input type="checkbox"/> Pregnant    | <input type="checkbox"/> Psychiatric Care   | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Bone Disorder        |
| <input type="checkbox"/> Nursing     | <input type="checkbox"/> Sinus problems     | <input type="checkbox"/> Glandular Problems       | <input type="checkbox"/> Eating Disorder      |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Chronic fatigue    | <input type="checkbox"/> High/Low Blood Pressure  | <input type="checkbox"/> Blood Disorder       |

List any significant illness not mentioned above: \_\_\_\_\_

Allergies: \_\_\_\_\_

List any drugs or medications now being taken: \_\_\_\_\_

I have had a Sleep Study: Y N Sleep Center Name: \_\_\_\_\_ Sleep Study Date: \_\_\_\_\_

Sleep Study Diagnosis: \_\_\_\_\_ AHI: \_\_\_\_\_ RDI: \_\_\_\_\_

I have tried CPAP: Y N I could not tolerate it due to: \_\_\_\_\_

What other therapies have you tried for breathing disorders?: \_\_\_\_\_

Any immediate family members diagnosed or treated for a sleep disorder?: \_\_\_\_\_

Family history of heart disease, high blood pressure, or diabetes?: \_\_\_\_\_

Do you consume alcohol/sedatives/caffeine within 2-3 hours of bedtime? How often?: \_\_\_\_\_

Do you snore? Y N Wake up during the night? Y N Do you have excessive daytime sleepiness? Y N

## DENTAL HISTORY

Any pain, soreness, or sensitivity in the teeth?	Y	N
Any difficulty with chewing, or opening/closing?	Y	N
Any issues with the jaw joint like clicking, popping, stiffness, pain?	Y	N
Any dental work planned that you know of?	Y	N
Have you had any previous orthodontic consultation or treatment?	Y	N

### Epworth Sleepiness Scale (ESS):

0 = would never doze, 1 = slight chance, 2 = moderate chance, 3 = high chance of dozing

Sitting and reading: \_\_\_\_ Sitting inactive in a public place: (theater or meeting) \_\_\_\_

As a passenger in a car for an hour without a break: \_\_\_\_ Sitting quietly after a lunch without alcohol: \_\_\_\_

Lying down to rest in the afternoon when circumstances permit: \_\_\_\_ Sitting and talking to someone: \_\_\_\_

In a car, while stopped for a few minutes in traffic: \_\_\_\_ Watching Television: \_\_\_\_ Total: \_\_\_\_

Score: 1-6 = Rested, 7-8 = Average, 9+ = Sleepy and should seek medical advice

Briefly state your chief concern: \_\_\_\_\_

Patient Signature (or Parent if minor): \_\_\_\_\_

I authorize the release of a full report of examination findings, diagnosis and proposed treatment 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 fees for treatment regardless of insurance coverage.

#### For Office Use:

		6											6		
		6											6		

Overbite: \_\_\_\_ Frenum: Y/N Diastema: \_\_\_\_ Hyg: \_\_\_\_ Profile: \_\_\_\_ P: \_\_\_\_ M: \_\_\_\_ D: \_\_\_\_

Overjet: \_\_\_\_ Crowding: \_\_\_\_ TMJ WNL?: Y N: \_\_\_\_

Tongue Level: L M H Gag?: Y N Swallow: \_\_\_\_ Tonsils: \_\_\_\_ Uvula: \_\_\_\_

Maxilla: \_\_\_\_ Mandible: \_\_\_\_ Airway Notes: \_\_\_\_

Patient Dx by Sleep Study with OSA? (ICD 327.23) Y N Candidate for Oral Appliance Therapy? Y N

Chief Complaint: \_\_\_\_\_

Summary: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Exam Fee: \_\_\_\_ Consult Fee: \_\_\_\_ PAN: \_\_\_\_ Photo: \_\_\_\_ HF: \_\_\_\_ Other: \_\_\_\_

Records Appt.: \_\_\_\_ Consult Appt.: \_\_\_\_ Approx. Fees: \_\_\_\_