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:

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

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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: _____

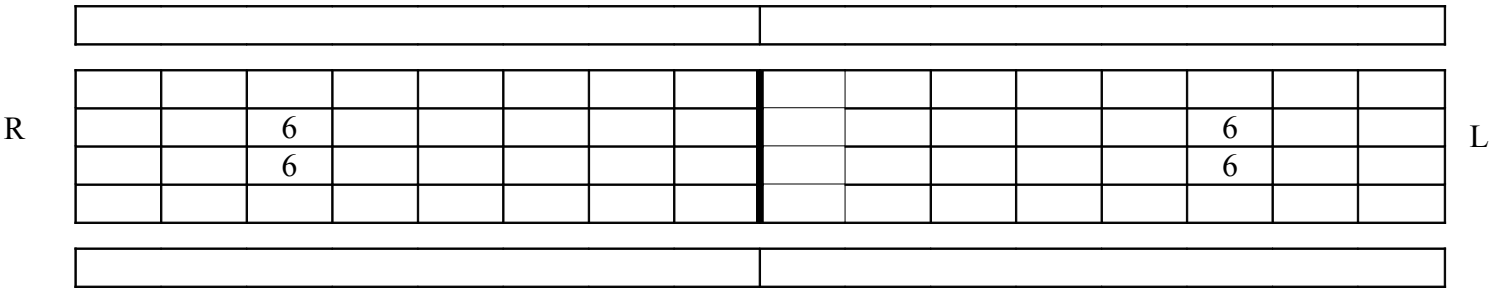
Score: 1-6 = Rested, 7-8 = Average, 9+ = Sleepy and should seek medical advice

Briefly state your chief concern: _____

Patient Signature (or Parent if minor): _____

I authorize the relase of a full report of examination findings, diagnosis and proposed treatment to any referring or treating dentist or physician.
I additionally authorize the relase 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:



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 Applicance Therapy? Y N

Chief Complaint: _____

Summary:_____

_____

_____

Recommendations: _____

Exam Fee: _____ Consult Fee: _____ PAN: _____ Photo: _____ HF: _____ Other: _____

Records Appt.: _____ Consult Appt.: _____ Approx. Fees: _____