Greenwich Sleep Apnea - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ___

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

The best time to contact me is: ☐ Morning ☐ Mid-Day ☐ Evening on ☐ Home phone ☐ Cell phone ☐ Work phone

Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Address: _____City:_____ State: _____ Zip: _____

Date of Birth (M/D/Y): ____ /____ /_____ Gender: ☐ M ☐ F Social Security Number (SSN): _____

Height: Feet____ Inches____ Weight (lbs): _____ Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Minor

Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____ Phone_____

REFERRED BY: _____

Employer Information

Employer: _____ Phone: (___) _____Fax: (___)_____

Address: _____City_____ State: _____Zip: _____

Health Insurance Information

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

Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____ /____ /_____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address_____ City_____ State: _____ Zip _____

Phone: (_____)_____Fax: (_____)_____ Email: _____

Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO IF**YES** , PLEASE COMPLETE THIS SECTION

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

Name of Insured (First, MI, Last): _____ Insured DOB___ /___ /_____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address_____ City_____ State: _____ Zip _____

Phone :(_____)_____ Fax: (_____)_____ Email: _____

Please present your secondary insurance card so we can photocopy it.

Medical Contacts

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

PRIMARY CARE DOCTOR: _____ Phone: _____

ENT: _____ Phone: _____

SLEEP DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

OTHER MD: _____ Phone: _____

OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ Date:_____

Greenwich Sleep Apnea Patient Questionnaire

EPWORTH SLEEPINESS SCALE

Sitting and Reading	_____	0 = No chance of dozing
Watching TV	_____	1 = Slight Chance of dozing
Sitting inactive in public place (theater)	_____	2 = Moderate Chance of dozing
As a car 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	_____	TOTAL = _____
In a car while stopped at a traffic light	_____	

THORNTON SNORING SCALE

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 (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other: _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

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)

On average, 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 TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER

Greenwich Sleep Apnea Patient Questionnaire

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? _____/ 7 Nights
When you wear your CPAP, how many hours per night do you wear it? _____hours per night

If you use or have used 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 CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI / stomach / intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ The device causes irritation due to air leaks
- ☐ Other:

_____
_____

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 a 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 and apnea and sleep quality.
_____
_____
_____

Greenwich Sleep Apnea Patient Questionnaire

PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures? 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, penicillin, etc):

_____ _____

MEDICATIONS – Please list all medications you are currently taking:

_____

MEDICAL HISTORY – Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

_____
_____
_____

Dental History

How would you describe your dental health? EXCELLENT GOOD FAIR POOR
Have you ever had teeth extracted? YES NO → **If YES, please describe**_____
Do you wear removable partials? YES NO
Do you wear full dentures? YES NO
Have you ever worn braces (orthodontics)? YES NO → **If YES, date completed:** _____
Does your TMJ (jaw joint) click or pop? YES NO → **Do you have pain in this joint?** YES NO
Have you had TMJ (jaw joint) surgery? YES NO
Have you ever had gum problems? YES NO → **If YES, 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 a 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 or Guardian Signature: _____ Date: _____