



Welcome

Sleep Apnea is more common than people realize. Sleep apnea is a disorder characterized by pauses in breathing or limited breathing. People with sleep apnea have problems with excessive daytime sleepiness and its linked to many other medical conditions such as heart disease, liver disease and diabetes. An Oral Appliance can help you and your bed partner get a good night's sleep and it can improve your health and quality of life. Please complete the following info so that we can better help you.

About You

Name: _____

Spouse Information: _____

I prefer to be called: _____

Spouse's Name: _____

Home Address: _____

Spouse's Employer: _____

Spouse's Name: _____

Home Phone: _____

Spouse's Dob: ____/____/____

Work Phone: _____

Cell Phone: _____

Medical Insurance

Email: _____

Subscriber Name: _____

SS#: _____

Relation To Patient: _____

DOB ____/____/____ Age ____

Subscriber Id Or SS#: _____

Marital Status: _____

Subscriber DOB: ____/____/____

Employer Name: _____

How did you hear about us? _____

Employer Address: _____

Occupation: _____

Are you currently under a physician's care? Yes No

Have you ever been hospitalized or had a major operation? Yes No

Have you ever had a serious head, concussion or neck injury? Yes No

| | |
|------------------|-------------------|
| Physicians Name: | Physicians Phone: |
| Pharmacy Name: | Pharmacy Phone: |

Sleep Apnea Questionnaire:

Do you smoke or use tobacco? Yes No

Do you snore loudly? Yes No

Do you often feel tired, fatigued or sleepy during the day? Yes No

Has anyone observed you stop breathing during your sleep? Yes No

Do you have or are you being treated for high blood pressure? Yes No

Are you currently on medication? Yes No

Please list all medications you are currently taking: _____

Please list any allergies: _____

| Conditions | | | | | | | | |
|--------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| AIDS/HIV' Positive | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatments | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis/Gout | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack Failure | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pace Maker | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathing Problem | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Concussions | <input type="checkbox"/> | <input type="checkbox"/> | Hives or Rash | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disorder | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Alcohol Abuse | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | | | |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform and necessary services that I may need during diagnosis and treatment with my informed consent, I understand that I am responsible for payment of services rendered.

Patient Signature: _____ Date: _____