CENLA Sleep SOLUTIONS

Patient Registration:

Date: _____

Patient Name: _____ ❍Mr. ❍Mrs. ❍Ms. ❍Dr.
First Middle Initial Last
Primary Care Physician: _____ Phone Number: _____
Responsible Party: _____ (If Someone other than patient)
Address: _____
Street City State Zip Code
Home Phone: _____ Work Phone: _____ Cell Phone: _____
❍ Male ❍ Female ❍Married ❍Single ❍Divorced ❍Separated ❍Widowed
DOB: ____/___/____ SSN: _____-_____-_____ Email: _____
Spouse Name: _____
❍Employed Student Status ❍Full time ❍Part time Height: _____
❍Allow spouse to review records
Family Dentist: _____ Phone Number: _____

Medical Insurance Information:

Primary Medical Insurance Information:
Name of Insured: _____
First Middle Initial Last
Policy/group No. _____ Relationship to insured: ❍Self ❍Spouse ❍Child ❍Other
Insurance ID No. _____ Insured DOB: ____/____/____ Plan Name: _____
Employer: _____ Insurance Company: _____
Insured Address if different than patient's
Address: _____
Street City State Zip Code

Patient Signature: _____

Secondary Insurance Information:

Secondary Medical Insurance Information
Name of Insured: _____
First Middle Initial Last
Policy/group No. _____ Relationship to insured: ❍Self ❍Spouse ❍Child ❍Other
Insurance ID No. _____ Insured DOB: ____/____/____ Plan Name: _____
Employer: _____ Insurance Company: _____
Insured Address if different than patient's
Address: _____
Street City State Zip Code

Patient Signature: _____

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No Chance of dozing	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing	
❍	❍	❍	❍	Sitting and reading
❍	❍	❍	❍	Watching Tv
❍	❍	❍	❍	Sitting inactive in public (theater or meeting)
❍	❍	❍	❍	As a passenger in a car for an hour without a break
❍	❍	❍	❍	Lying down to rest in the afternoon
❍	❍	❍	❍	Sitting and talking to someone
❍	❍	❍	❍	Sitting quietly after a lunch without alcohol
❍	❍	❍	❍	In a car, while stopped for a few minutes in traffic

Sleep Screening Questionnaire

What are the chief complaints for which you are seeking treatment?

- ❍ CPAP intolerance
- ❍ Difficulty Concentrating
- ❍ Excessive daytime sleepiness
- ❍ Fatigue
- ❍ Forgetfulness
- ❍ Frequent Snoring
- ❍ Gasping causing waking up
- ❍ Impaired thinking
- ❍ Insomnia
- ❍ Morning Headaches
- ❍ Nighttime choking spells
- ❍ Snoring which affects the sleep of others
- ❍ Witnessed cessation of breathing
- ❍ Irritability and Mood Swings

Other: _____

_____

_____

Patient Signature

Because of HIPPA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible or all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____

Sleep Studies

If you have had a Sleep study, please check one of the following:
❍Home Sleep Study ❍Polysomnographic evaluation at a sleep disorder center
Sleep Center Name: _____
Sleep Study Date: ____/____/____

CPAP Intolerance

(Continuous Positive Airway Pressure device)
If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

❍Refuses CPAP
❍Noise disturbing sleep and/or bed partner's sleep
❍Claustrophobic associations
❍Mask leaks
❍CPAP restricted movements during sleep
❍An unconscious need to remove the CPAP
❍Inability to get the mask to fit properly
❍CPAP does not seem to be effective
❍does not resolve symptoms
❍Discomfort from headgear
❍Pressure on the upper lip causing tooth related problems
❍Noisy
❍Disturbed or interrupted sleep
❍Latex Allergy
❍Cumbersome

Other: _____
_____
_____

Other Therapy Attempts

❍Dieting
❍BiPap
❍Weight Loss
❍Uvulectomy (but continues to have symptoms)
❍Surgery (Uvuloplasty)
❍Uvuloplasty (but continues to have symptoms)
❍Surgery (Uvulectomy)
❍Positional therapy (side sleeping)
❍Pillar procedure
❍Nasal Strips
❍Smoking Cessation
❍CPAP

Patient Signature: _____

Medical History Questionnaire

Allergies:

❍No known allergies
❍Antibiotics
❍Aspirin
❍Barbiturates
❍Codeine
❍Iodine
❍Latex
❍Local Anesthetics
❍Metals
❍Penicillin
❍Plastic
❍Sedatives
❍Sleeping Pills
❍Sulfa Drugs

Other: _____

Current Medications:

_____
_____
_____
_____

Medical History:

Check all the apply

❍Acid Reflux
❍Asthma
❍Blood Pressure – Low
❍Chronic Fatigue
❍Current Pregnancy
❍Dizziness
❍Fibromyalgia
❍Heart Murmur
❍Hemophilia
❍Immune system disorder
❍Kidney Problems
❍Mood disorder
❍Neuralgia
❍Prior orthodontic treatment
❍Sinus Problems
❍Thyroid disorder
❍Recreational Drugs
❍Anemia
❍Autoimmune Disorder
❍Bruising Easily
❍Chronic Pain
❍Depression
❍Emphysema
❍Glaucoma
❍Heart Pacemaker
❍Hepatitis
❍Insomnia
❍Liver Disease
❍Multiple Sclerosis
❍Osteoarthritis
❍Radiation treatment
❍Sleep Apnea
❍Tuberculosis
❍HIV/AIDS
❍Atherosclerosis
❍Bleeding Easily
❍Cancer
❍COPD
❍Diabetes
❍Epilepsy
❍Gout
❍Heart Valve Replacement
❍Hypertension
❍Ischemic Heart Disease (reduced blood supply)
❍Meniere's disease
❍Muscular dystrophy
❍Osteoporosis
❍Rheumatic fever
❍Stroke
❍Tumors
❍Arthritis
❍Blood Pressure-High
❍Chemotherapy
❍Coronary Heart Disease
❍Difficulty Sleeping
❍Excessive Daytime Sleepiness
❍Heart Attack
❍Hypoglycemia
❍Mitral Valve Prolapse
❍Nasal Allergies
❍Parkinson's Disease
❍Rheumatoid arthritis
❍Tendency for ear infections
❍Urinary disorders

Other: _____
_____
_____

Patient Signature: _____ Date: _____

Surgical Operations

❍Appendectomy ❍Back ❍Ear ❍Gallbladder
❍Heart ❍Hernia Repair ❍Lung ❍Nasal
❍Thyroid ❍Tonsillectomy ❍Uvulectomy ❍Periodontal

Other: _____
_____

Family History

Has any member of your family (parent, sibling, or grandparent) had:

❍Cancer ❍Heart Disease ❍Diabetes ❍High Blood Pressure
❍Stroke ❍Sleep Disorder ❍Obesity ❍Thyroid disorder
❍Father snores ❍Mother snores ❍Father has sleep apnea
❍Mother has sleep apnea

Social History

Patient's Occupation: _____ Employer: _____
Tobacco Use: Cigarettes ❍Never smoked ❍Current Smoker ❍Quit
# of packs per day ____ When did you quit? _____
# of years _____
Other tobacco: ❍Pipe ❍Cigar ❍Snuff ❍Chew

Alcohol Use: Do you drink alcohol? ❍Yes ❍No If yes, # of drinks per week _____
Caffeine Intake: ❍None ❍Coffee/Tea/Soda # of cups per day _____
Additional: ❍Regular Exercise

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I certify that the medical history information is complete and accurate.
Patient Signature: _____ Date: _____