Today's Date: _____

Patient's Name: _____ Gender: _____

Patient Date of Birth: _____

If Child, Parent's Name: _____

How you wish to be addressed: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Employer: _____

Position: _____

Spouse Name: _____

Spouse Employer: _____

Position: _____

Who is responsible for this account? _____

Purpose of first visit: _____

Other Family Members in this practice: _____

Whom may we thank for this referral: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

CONSENT: I consent to the diagnostic procedures and treatment necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of my records shall be effective until I revoke it in writing. I attest to the accuracy of the information on this page.

Patient or Guardian Signature: _____ **Date:** _____

Our practice is not affiliated with any dental or medical insurance plans as a preferred provider. As a result, we ask for payment at the time services are rendered. We will be happy to assist by providing our patients with information to furnish their insurance companies for potential reimbursement.

Medical Insurance

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

Dental Insurance

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

Patient Name:_____ **Date of Birth:**_____/_____ /_____

COMMENTS: OFFICE USE ONLY

1. Reason for today's visit: _____
2. Are you aware of any problems? _____
3. How long since your last dental visit? _____
4. What was done at that time?_____
5. Previous Dentist's Name: _____
6. When was the last time your teeth were cleaned?_____

CIRCLE THE APPROPIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE.

7. Have you made regular dental visits?_____ ☐YES ☐NO
8. Were dental x-rays taken?_____ ☐YES ☐NO
9. Have you lost any teeth or have any teeth been removed?___ ☐YES ☐NO
    a. Why? _____
10. Have they been replaced?_____ ☐YES ☐NO
11. How have they been replaced?_____ ☐YES ☐NO
    a. Fixed Bridges_____When? _____
    b. Removable Bridge_____When? _____
    c. Denture_____When? _____
    d. Implant_____ When?_____
12. Are you happy with the replacement?_____ ☐YES ☐NO
    a. If not, please explain_____
13. Would you like to know about permanent replacement?____ ☐YES ☐NO
14. Have you ever had any problems or complications with previous dental treatment?_____ ☐YES ☐NO
15. Do you clench or grind your teeth?_____ ☐YES ☐NO
16. Does your jaw pop or click? _____ ☐YES ☐NO
17. Have you experienced any pain or soreness in the muscles in your face or around your ear? _____ ☐YES ☐NO
18. Do you have frequent headaches,neckaches,shoulder aches? ☐YES ☐NO
19. Does your food get caught in your teeth?_____ ☐YES ☐NO
20. Are any of your teeth sensitive to ☐HOT ☐COLD ☐SWEETS ☐PRESSURE?
21. Do your gums bleed or hurt? _____ ☐YES ☐NO
22. Have you ever had gum treatment or surgery? _____ ☐YES ☐NO
    a. What? _____
    b. Where? _____
    c. When?_____
23. Do you feel your breath is offensive at times? _____ ☐YES ☐NO
24. How often do you brush your teeth daily? _____ ☐YES ☐NO
25. Do you use dental floss? _____ ☐YES ☐NO
    a. How often? _____
26. Are any of your teeth: ☐LOOSE? ☐TIPPED? ☐SHIFTED? ☐CHIPPED?
27. Are you happy with the appearance of your teeth?_____ ☐YES ☐NO
28. How do you feel about your teeth in general?_____
29. Have you had orthodontic work?_____ ☐YES ☐NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
31. Do you have any questions or concerns?_____ ☐YES ☐NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIN'S SIGNATURE _____

DENTIST'S SIGNATIURE _____

Adult New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Chief Complaint: _____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____# of cups of tea per day

_____ # cans or glasses of soda per day _____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol: ☐ None ☐ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

---

Tobacco: ☐ None ☐ Yes _____ # of packs per day _____ # of years

---

Recreational Drugs (such as marijuana or cocaine): ☐ None ☐ Yes

If yes, which ones? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children: ☐ No ☐ Yes How many? _____

Pets: ☐ No ☐ Yes How many? _____ **What type of pet**? _____

Do you have any children or pets that sleep in your bedroom? ☐ No ☐ Yes _____

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite: Sweats:	❑ Yes ❑ No
Fever:	❑ Yes ❑ No
Fatigue:	❑ Yes ❑ No
Weight Gain:	❑ Yes ❑ No
Weight Loss:	❑ Yes ❑ No

Gastrointestinal:

GERD/Heartburn/Indigestion:	❑ Yes ❑ No
Black or Bloody Stools: Diarrhea:	❑ Yes ❑ No
Nausea/Vomiting:	❑ Yes ❑ No
Jaundice:	❑ Yes ❑ No
Abdominal Pain	❑ Yes ❑ No

Respiratory:

Cough:	❑ Yes ❑ No
Asthma:	❑ Yes ❑ No
Wheezing:	❑ Yes ❑ No
Poor Exercise Tolerance:	❑ Yes ❑ No

Genitourinary:

Bed Wetting:	❑ Yes ❑ No
Frequent Urination:	❑ Yes ❑ No
Difficulty Urinating:	❑ Yes ❑ No
Blood in Urine:	❑ Yes ❑ No
Erectile dysfunction	❑ Yes ❑ No

REVIEW OF SYMPTOMS

Allergy/Immunology:

Sneezing: ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Itchy Eyes or Nose: Hives: ❑ Yes ❑ No

Nasal allergies/Hay fever/

Nasal Congestion ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss: ❑ Yes ❑ No

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No

Muscle Pain: ❑ Yes ❑ No

Red or Swollen Joints: ❑ Yes ❑ No

Temporomandibular Joint

(TMJ) pain/jaw discomfort ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

Cardiac:

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Skin:

Unusual Moles : ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

Endocrine:

Heat Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Cold Hands/Feet: ❑ Yes ❑ No

Decreased Libido: ❑ Yes ❑ No

Neurologic:

Weakness: ❑ Yes ❑ No

Seizures: ❑ Yes ❑ No

Involuntary Tongue Biting: ❑ Yes ❑ No

Passing Out: ❑ Yes ❑ No

Dizziness: ❑ Yes ❑ No

Headaches: ❑ Yes ❑ No

Numbness: ❑ Yes ❑ No

Restless Leg Syndrome: ❑ Yes ❑ No

Psych:

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Difficulty with Focus: ❑ Yes ❑ No

Trouble Concentrating: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

- ❑ High blood pressure/hypertension
- ❑ Heart disease
- ❑ Stroke
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes
- ❑ Overweight/obesity
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Anxiety
- ❑ Chronic insomnia
- ❑ Restless legs syndrome
- ❑ Multiple sclerosis
- ❑ Sleep walking

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male ☐ Female ☐

Have you ever had a sleep test administered? ☐ yes ☐ no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? ☐ yes ☐ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? ☐ yes ☐ no

Are you happy with your CPAP or Sleep Appliance? ☐ yes ☐ no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, iin contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have effected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in public place (like a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Analyze Your Score

Interpretation:	
From 0-7	It is unlikely that you are abnormally sleepy
From 8-9	You have an average amount of daytime sleepiness
From 10-15	You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention
From 16-20	You are excessively sleep and should consider seeking medical attention

Berlin Questionnaire©

Sleep Apnea

Height (m) _____ Weight (kg) _____ Age _____ ☐ Male / ☐ Female

Please choose the correct response to each question.

Category 1

1. Do you snore?
☐ a. Yes
☐ b. No
☐ c. Don't know

If you answered 'yes':

2. You snoring is:
☐ a. Slightly louder than breathing
☐ b. As loud as talking
☐ c. Louder than talking

3. How often do you snore?
☐ a. Almost every day
☐ b. 3-4 times per week
☐ c. 1-2 times per week
☐ d. 1-2 times per month
☐ e. Rarely or never

4. Has your snoring ever bothered other people?
☐ a. Yes
☐ b. No
☐ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
☐ a. Almost every day
☐ b. 3-4 times per week
☐ c. 1-2 times per week
☐ d. 1-2 times per month
☐ □ e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
☐ a. Almost every day
☐ b. 3-4 times per week
☐ c. 1-2 times per week
☐ d. 1-2 times per month
☐ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
☐ a. Almost every day
☐ b. 3-4 times per week
☐ c. 1-2 times per week
☐ d. 1-2 times per month
☐ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
☐ a. Yes
☐ b. No

If you answered 'yes':

9. How often does this occur?
☐ a. Almost every day
☐ b. 3-4 times per week
☐ c. 1-2 times per week
☐ d. 1-2 times per month
☐ e. Rarely or never

Category 3

10. Do you have high blood pressure?
☐ Yes
☐ No
☐ Don't know

Scoring Berlin Questionnaire

The questionnaire consists of 3 categories related to the risk of having sleep apnea. Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores in the symptom categories.

Categories and Scoring:
Category 1: items 1, 2, 3, 4, and 5;
Item 1: if '**Yes**', assign **1 point**
Item 2: if '**c**' or '**d**' is the response, assign **1 point**
Item 3: if '**a**' or '**b**' is the response, assign **1 point**
Item 4: if '**a**' is the response, assign **1 point**
Item 5: if '**a**' or '**b**' is the response, assign **2 points**
Add points. *Category 1 is positive if the total score is 2 or more points*.

Category 2: items 6, 7, 8 (item 9 should be noted separately).
Item 6: if '**a**' or '**b**' is the response, assign **1 point**
Item 7: if '**a**' or '**b**' is the response, assign **1 point**
Item 8: if '**a**' is the response, assign **1 point**
Add points. *Category 2 is positive if the total score is 2 or more points.*

Category 3 is positive if the answer to item 10 is '**Yes**' or if the BMI of the patient is greater than 30kg/m_2.
(BMI is defined as weight (kg) divided by height (m) squared, i.e.., kg/m_2).

High Risk: if there are 2 or more categories where the score is positive.

Low Risk: if there is only 1 or no categories where the score is positive.

Additional Question: item 9 should be noted separately.