Kaplan Sleep Solutions - 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:_____

Kaplan Sleep Solutions 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

Kaplan Sleep Solutions 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: ______________________________________
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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.

____
____
____

Kaplan Sleep Solutions 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: ________________