SLEEP SCREENING QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

TODAY'S DATE: _____

☐ MR. ☐ MS ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ BIRTH DATE _____ ☐ Male ☐ Female

ADDRESS: _____

CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN _____

ADDRESS _____

INSURANCE

MEMBER NUMBER _____

GROUP NUMBER _____

PLAN NUMBER _____

NAME OF PRIMARY CARE PHYSICIAN _____

HEIGHT: _____ feet _____ inches

WEIGHT: _____ pounds

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please <u>number</u> the complaints with #1 being the most important.

____ Frequent heavy snoring
____ which affects the sleep of others
____ Significant daytime drowsiness
____ I have been told that "I stop breathing" when sleeping.
____ Difficulty falling asleep
____ Gasping when waking up
____ Nighttime choking spells
____ Feeling unrefreshed in the morning

____ Morning hoarseness
____ Morning headaches
____ Swelling in ankles or feet
____ Nocturnal teeth grinding
____ Jaw pain
____ Facial pain
____ Jaw clicking

Other: _____ _____

Patient Signature _____ Date _____

THE EPWORTH SLEEPINESS SCALE

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

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. 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	☐	☐	☐	☐

Patient Signature _____ Date _____

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

If Yes:

Sleep Center Name and Location _____

_____

Sleep Study Date _____

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The evalution confirmed a diagnosis of: ☐ *mild* ☐ *moderate* ☐ *severe* obstructive sleep apnea

The evaluation showed an RDI of _____ and an AHI of _____

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:

I could not tolerate the CPAP device due to:

- ☐ mask leaks
- ☐ I was unable to get the mask to fit properly
- ☐ discomfort caused by the straps and headgear
- ☐ disturbed or interrupted sleep caused by the presence of the device
- ☐ noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ pressure on the upper lip causing tooth related problems
- ☐ a latex allergy
- ☐ claustrophobic associations
- ☐ an unconscious need to remove the CPAP apparatus at night

Other: _____ _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

Patient Signature _____ Date _____

List any medications which have caused an allergic reaction:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:

_____
_____
_____
_____

List any medications you are currently taking:

Y☐ N☐ Antacids
Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Antidepressants
Y☐ N☐ Anti-inflammatory drugs (non-steroid)
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ High blood pressure medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other current medications: _____
_____
_____

Medical History

Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Chronic sinus problems
Y☐ N☐ Chronic fatigue
Y☐ N☐ Congestive heart failure
Y☐ N☐ Current pregnancy
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent sore throats
Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
Y☐ N☐ Hay fever
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pounding or beating irregularly during the night
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Neck
☐ Head ☐ Mouth ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nighttime sweating
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Thyroid problems
Y☐ N☐ Tonsillectomy (have had)
Y☐ N☐ Wisdom teeth extraction

Other medical history:

_____
_____
_____
_____

Patient Signature _____ Date _____

Family History

1. Have any members of your family (blood kin) had:
   - Yes ☐ No ☐ Heart disease
   - Yes ☐ No ☐ High blood pressure
   - Yes ☐ No ☐ Diabetes

2. Have any immediate family members been diagnosed or treated for a sleep disorder? Yes ☐ No ☐

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

Never ☐ Once a week ☐ Several days a week ☐ Daily

Do you smoke? ☐ Yes ☐ No If yes, enter the number of packs per day (or other description of quantity): _____

Do you use chewing tobacco? ☐ Yes ☐ No

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____

W E S T F I E L D O R A L S U R G E R Y A S S O C I A T E S
320 Lenox Avenue · Westfield, New Jersey 07090

FINANCIAL AGREEMENT

Please read the following and sign in the appropriate locations. If you have any questions whatsoever with regard to this agreement, please inquire at the front desk.

A. I _____, the undersigned, have insurance with _____ (insurance company,) and assign directly to Dr. Philip R. Geron or Westfield Oral Surgery Associates, all benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Deductibles or co-payments, if applicable, must be made at time of service.

Signature_____ Date_____

B. **Financial Agreement**. I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance plans. Estimated fees for service will be provided upon request after examination. If for some unusual reason, payment cannot be made in full at the time of service, any fees still not paid within 30 days of service will be billed at 1.5 percent monthly interest, and all legal/collection costs will be the patient's/guardian's responsibility.

Signature_____ Date_____

C. **Minor/Child Consent**. I, _____ (parent/guardian), being the parent of _____ (child's name), do hereby request and authorize the staff to perform necessary services for my child, including, but not limited to, examination, X-rays, administration of appropriate anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature_____ Date_____

If alternate financial agreement has been made, this will be documented on this financial agreement plan, as noted above.

W E S T F I E L D O R A L S U R G E R Y A S S O C I A T E S
320 Lenox Avenue · Westfield, New Jersey 07090

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____