Date: ___________________ First Name: _______________________ M.I.: ______ Last Name: ________________________

SS#: _______________________ Birthday: _____________________________ Email: ________________________________

Address: ____

City, State, Zip: ____

Home Phone: _______________________ Cell Phone: ______________________ Work Phone: ______________________

Marital Status: ❑ Married ❑ Unmarried Gender: ❑ Male ❑ Female Height: ______’ ______”

INSURANCE INFORMATION

Payer Name: ____

Address: ____

City, State, Zip: ____

Insurance Type: ❑ Medicare ❑ Medicaid ❑ Tricare Champus ❑ Champva
❑ Group Health Plan ❑ FECA Black Lung ❑ Other

Medicare #: ____

Patient’s Status: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student

Patient’s Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Insured: First Name: ___________________________ M.I.: _______ Last Name: ____________________________

Policy/Group #: ____

Insured’s Birth Date: (MM/DD/YYYY) ____ Gender: ❑ Male ❑ Female

Address: ____

City, State, Zip: ____

Telephone: (_____)__________________ Employer’s Name or School Name: ____________________________________

Insurance Plan Name or Program Name: ____

Is There Another Benefit or Plan: ❑ Y ❑ N

Other Insured’s Name: First Name: ________________________ M.I.: _______ Last Name: __________________________

Other Insurance Policy/Group #: ____

Other Insured’s Birth Date: (MM/DD/YYYY) ______________________________________ Gender: ❑ Male ❑ Female

Employer’s Name or School Name: ____

Insurance Plan Name or Program Name:____

Signature of Patient ____ Date __________________________________

CHIEF COMPLAINTS

Please check off your chief complaints

- ❑ CPAP intolerance
- ❑ Difficulty falling asleep
- ❑ Fatigue
- ❑ Frequent heavy snoring
- ❑ Frequent heavy snoring which affects others sleep
- ❑ Gasping when waking up
- ❑ Nighttime choking spells
- ❑ Significant daytime drowsiness
- ❑ Sleepiness while driving
- ❑ Witnessed apneic events
- ❑ Morning Headaches
- ❑ Takes CPAP off every night
- ❑ Feels CPAP is not helping

ALLERGENS

List any medications/substances that have caused an allergic reaction:

- ❑ No known allergens
- ❑ Acrylic
- ❑ Antibiotics
- ❑ Aspirin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local anesthetics
- ❑ Metals
- ❑ Nickel
- ❑ Polyesther
- ❑ Penicillin
- ❑ Plastic
- ❑ Sedatives
- ❑ Sleeping pills
- ❑ Sulfa drugs

Other Allergens:

____

____

____

CURRENT MEDICATIONS

Enter all medications you are currently taking:

Medicine:

____

____

____

SURGERIES

- ❑ Appendectomy
- ❑ Back
- ❑ Ear
- ❑ Gallbladder
- ❑ Heart
- ❑ Hernia repair
- ❑ Lung
- ❑ Nasal
- ❑ Thyroid
- ❑ Tonsillectomy
- ❑ Uvulectomy
- ❑ UPPP
- ❑ Periodontal

FAMILY HISTORY

Has any member of your family 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
- ❑ Father uses CPAP
- ❑ Mother uses CPAP
- ❑ Sibling uses CPAP

SOCIAL HISTORY

Current Occupation: ____________________________

Current Employer: ____________________________

- ❑ Never smoked
- ❑ Currently smoking

Packs per day: ________ Years smoking: ________

- ❑ Quit smoking

Date You Quit Smoking: ____________________________

- ❑ Smokes pipe ❑ Smokes cigars
- ❑ Uses snuff ❑ Uses chewing tobacco

Drink alcohol? ❑ Y ❑ N Drinks per week: _______

Drink coffee/tea/soda? ❑ Y ❑ N Cups per day: ____

Additional Items

- ❑ Regular exercise

MEDICAL HISTORY

Item:	Never	Current	Past Date
Acid reflux	❑	❑	❑
Anemia	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Arthritis	❑	❑	❑
Asthma	❑	❑	❑
Autoimmune disorder	❑	❑	❑
Bleeding easily	❑	❑	❑
Blood pressure - High	❑	❑	❑
Blood pressure - Low	❑	❑	❑
Bruising easily	❑	❑	❑
Cancer	❑	❑	❑
Chemotherapy	❑	❑	❑
Chronic fatigue	❑	❑	❑
Chronic pain	❑	❑	❑
COPD	❑	❑	❑
Current pregnancy	❑	❑	❑
Depression	❑	❑	❑
Diabetes	❑	❑	❑
Difficulty sleeping	❑	❑	❑
Dizziness	❑	❑	❑
Emphysema	❑	❑	❑
Epilepsy	❑	❑	❑
Fibromyalgia	❑	❑	❑
Glaucoma	❑	❑	❑
Gout	❑	❑	❑
Heart attack	❑	❑	❑
Heart disorder	❑	❑	❑
Heart murmur	❑	❑	❑
Heart pacemaker	❑	❑	❑
Heart valve replacement	❑	❑	❑
Hemophilia	❑	❑	❑
Hepatitis	❑	❑	❑
Hypertension	❑	❑	❑
Hypoglycemia	❑	❑	❑
Immune system disorder	❑	❑	❑
Kidney problems	❑	❑	❑
Liver disease	❑	❑	❑
Meniere’s disease	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Multiple sclerosis	❑	❑	❑
Muscular dystrophy	❑	❑	❑
Nasal allergies	❑	❑	❑
Neuralgia	❑	❑	❑
Osteoarthritis	❑	❑	❑
Osteoporosis	❑	❑	❑

Item:	Never	Current	Past Date
Parkinson’s disease	❑	❑	❑
Psychiatric care	❑	❑	❑
Radiation treatment	❑	❑	❑
Rheumatic fever	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Sinus problems	❑	❑	❑
Sleep apnea	❑	❑	❑
Stroke	❑	❑	❑
Tendency for ear infections	❑	❑	❑
Thyroid disorder	❑	❑	❑
Tuberculosis	❑	❑	❑
Tumors	❑	❑	❑
Urinary disorders	❑	❑	❑
Prior orthodontic treatment	❑	❑	❑

Enter any other conditions:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

EPWORTH

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

	None	Slight	Moderate	High
Sitting and Reading	❑	❑	❑	❑
Watching TV	❑	❑	❑	❑
Sitting inactive in a public place (e.g. a theatre 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	❑	❑	❑	❑

BED PARTNER SURVEY

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired?

	None	Slight	Moderate	High
Sitting and Reading	❑	❑	❑	❑
Watching TV	❑	❑	❑	❑
Sitting inactive in a public place (e.g. a theatre 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	❑	❑	❑	❑

CPAP INTOLERANCE

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section:

- ❑ Mask leaks
- ❑ Inability to get the mask to fit properly
- ❑ Discomfort from headgear
- ❑ Disturbed or interrupted sleep
- ❑ Noise disturbing 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 problems
- ❑ Latex allergy
- ❑ Claustrophobic associations
- ❑ An unconscious need to remove the CPAP
- ❑ Does not resolve symptoms
- ❑ Noisy
- ❑ Cumbersome
- ❑ Does not want to use CPAP

OTHER THERAPY ATTEMPTS

What other therapies have you had?

- ❑ Dieting
- ❑ Weight loss
- ❑ Surgery (Uvuloplasty)
- ❑ Surgery (Uvulectomy)
- ❑ Pillar procedure
- ❑ Smoking cessation
- ❑ CPAP
- ❑ BiPap
- ❑ Uvulectomy (but continues to have symptoms)
- ❑ Uvuloplasty (but continues to have symptoms)
- ❑ Tonsilectomy

Enter any other conditions:

____

____

____

SLEEP HISTORY

Previous Diagnosis

Previously diagnosed with obstructive sleep apnea? ❑ Y ❑ N

If yes, when was it: ________ Years Ago ________ Months Ago ________ Days Ago

Snoring is reported as:

❑ Snoring is reported

Frequency: ❑ Every Night ❑ Seldom ❑ Never ❑ Daily ❑ Often

Severity: ❑ Light ❑ Moderate ❑ Loud

❑ Worse during supine sleep (on back)

❑ Worse following alcohol late at night

Witnessed apneas are:

❑ Worse during supine sleep

❑ Worse following alcohol late at night

❑ Apneas have been witnessed by: ____

Sleep

How long does it take to fall asleep? ____________ Minutes

Normally go to bed at: ____________ ❑ AM ❑ PM

Hours you sleep per night: ____________

Are you using a sleep aid: ❑ Y ❑ N

If so, currently taking the medication:

❑ Bruxism

❑ Dry mouth

❑ Excessive movements

❑ Gasping

❑ Hypnagogic Hallucinations (at sleep onset)

❑ Restless legs

❑ Waking up and having difficulty returning to sleep

❑ Dreaming

❑ Frequency of nocturnal urination (# of times): ______________

❑ Not to sleep supine

❑ Sleep on her sides

❑ Sleeps on their sides

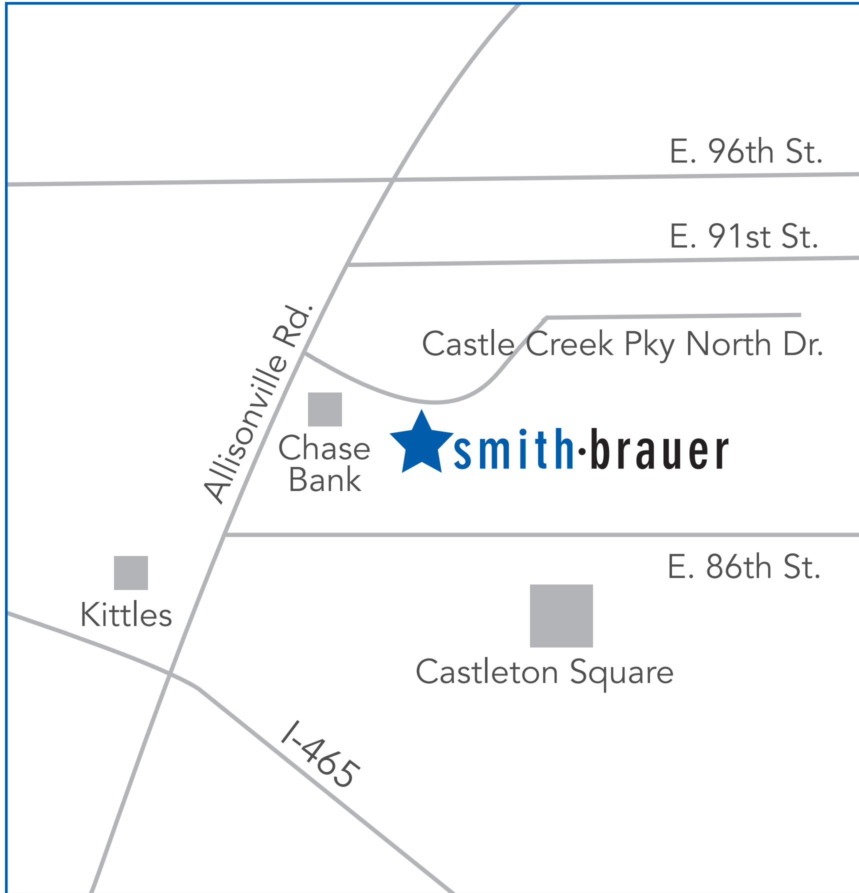
Wake

Sleepy while driving: ❑ Y ❑ N

❑ Awakens unrefreshed

❑ Has morning headaches

Naps: ❑ Daily ❑ Never ❑ Occasionally



DIRECTIONS TO DENTAL SLEEP MEDICINE OF INDIANA

Located at:
Smith-Brauer Family & Cosmetic Dentistry
8800 North on Allisonville Road
5625 Castle Creek Parkway North Drive
Indianapolis, IN 46250
p: 317.585.0008
f: 317.585.0006

info@snoringindiana.com
www.snoringindiana.com

Directions from South, East and West

Take I-465 to the Allisonville Road Exit. Go north on Allisonville Road. (You will pass 86th Street and at the next stop light you will see a Chase Bank on the eastside.) At the light go east (turn right). We are the first building east of Chase Bank on Castle Creek Parkway North Drive.

Directions from the North

Take Allisonville Road south past 91st Street. At the next stoplight turn east (left) onto Castle Creek Parkway North Drive. We are the first building east of Chase Bank.

For assistance call:

317.585.0008

Dental Sleep Medicine of Indiana

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ____

SECTION B: TO THE PATIENT–PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager
Telephone: 317-585-0008 Fax: 317-585-0006

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.

Signature: ____ Date: ________________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:

Patient: ____ Relationship ____________________

Patient: ____ Relationship ____________________

Patient: ____ Relationship ____________________

Patient: ____ Relationship ____________________

Patient: ____ Relationship ____________________

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: ________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Dental Sleep Medicine of Indiana

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

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

____
Please Print Name

____
Date

FOR OFFICE USE ONLY

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

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

____

____

____

5625 Castle Creek Parkway North Drive
Indianapolis, IN 46250
p: 317.585.0008 f: 317.585.0006
www.snoringindiana.com