CROSSINGS CLINIC
dental sleep apnea center

LOUISVILLE DENTAL
SLEEP MEDICINE, PLLC

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
Crossings Clinic and Louisville Dental Sleep Medicine 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. INITIAL: _____ Date:_____

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Patient Questionnaire - 1

Epworth Sleepiness Scale

Sitting and Reading	_____
Watching TV	_____
Sitting inactive in public place (theater)	_____
As a car passenger for an hour without a break	_____
Lying down in the afternoon to rest	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped at a traffic light	_____
TOTAL	_____

0 =No chance of dozing
1 =Slight Chance of dozing
2 = Moderate Chance of dozing
3 = High Chance of dozing

Thornton Snoring Scale

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects others when I am sleeping away from home	_____
TOTAL	_____

0 =Never
1 = 1 night/week
2 = 2-3 nights/week
3 = 4+ nights/week

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

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Patient Questionnaire - 2

Sleep Study/CPAP History

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? _____ out of 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
- ☐ Decreased 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

Dental Device History

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:

_____

_____

Surgical History

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: _____

Date: _____ Surgeon: _____ Surgery: _____

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.

_____

_____

_____

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Patient Questionnaire - 3

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? _____

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: _____