PATIENT INFORMATION

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Last Name **First** **Middle** **Preferred Name**

Date of Birth **Social Security Number** **Spouse Name or Parent Name**

Male Female (circle one) **Single Married Child** (circle one)

Children's Names

Street Address **Apt#** **City** **State** **Zip**

Home Number **Work Number / Ext** **Cell Number**

E-Mail_____ **Fax**_____

Preferred Payment Method (circle one): **Credit Card** **Other** **Cash/Check Insurance Only**

Primary Insurance:_____ **Secondary Insurance:**_____

Please provide a copy of your insurance card and driver's license.

Name of emergency contact_____ **Phone**_____

Whom may we thank for referring you to our office? _____

Last Dentist Name_____ **Date of last visit**_____

Office Phone Number _____

What TWO days work best for you to attend your appointments?
Monday Tuesday Wednesday Thursday Friday

What time of Day?
Early Morning Mid-Morning Noon Afternoon

Employer Name_____ **Position** _____

Interests and hobbies _____

_____

***I agree and understand (regardless of insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. Our office accepts payment from insurance as a courtesy to our patients. I am authorizing DFW Sleep Solutions to receive benefits directly from my benefit carrier and file any disputes with the Texas Insurance Commissioner's office. I am authorizing DFW Sleep Solutions to render dental services which include: radiographs and oral examination. I certify that the information provided is accurate to the best of my knowledge and will notify the receptionist of any changes to the above information.

_____

Printed Name of Patient / Legal Guardian Relationship to patient

_____

Signature of Patient / Legal Guardian Date

NAME_____ DATE_____

The following information is to be reviewed by the doctor and will be held in strictest confidence. It is important that you complete this medical history form in its entirety so we may accurately diagnose and treat you, according to your general health and wellbeing. If you have questions or require assistance in completing this medical history form, please ask our staff for help. Please return this completed form to the receptionist. Thank you for allowing us to serve your dental care health needs.

What brings you here today? Information? Treatment?_____

What do you think is causing your problem? _____

Over the past 6-12 months have your symptoms: (circle one) Improved Worsened Stayed the same

Anything that makes your condition worse or better? _____

What additional treatments have you tried? (homeopathic/holistic etc.) _____

ABOUT YOU

Are you in good health? YES NO

Are you presently under the care of a physician?

YES NO

If yes, what is the condition or nature of illness?

_____

Physician's name and phone number or N/A

_____

Date of last physical exam _____

Have you been hospitalized or had a major illness, operation, or injury in the last five years

YES NO

If yes, please explain _____

_____

_____

Please List all medications you are currently taking
(prescription, over the counter, any herbal herbal remedies, supplements)

_____

_____

**Are you allergic to any drugs or medications?

YES NO

If yes, please list _____

_____

**Have you ever had a problem with dental anesthetic? YES NO

If yes, please explain reaction_____

_____

**Are you allergic to latex? YES NO

If yes, please explain reaction _____

**Are you allergic to metal? YES NO

If yes, please explain reaction _____

DENTAL HISTORY-Please answer these in order to check for proper fit for oral appliance therapy:

Do you have pain or clicking in your jaw?

YES NO

Do you clench or grind your teeth?

YES NO

Have you ever had TMJ treatment?

YES NO

Have you ever had sores in or around your mouth, which occasionally return?

YES NO

Do you have any discomfort in your mouth presently? YES NO

Are your teeth sensitive to: (circle if any)

SWEETS COLD HEAT

Have you ever had braces? YES NO

Have you ever suffered major injury to head and/or neck? YES NO

Have you ever been diagnosed with periodontal disease? YES NO

Do your gums bleed when you brush your teeth YES NO

Are you aware of any swelling or lump in your mouth? YES NO

Are you aware of any habits (thumb sucking, nail biting, mouth breathing, etc)?

YES NO

If yes, please indicate _____

_____

Do you understand that some dental conditions only get worse without treatment? _____

HEALTH HISTORY
ALL THE FOLLOWING INFORMATION IS STRICTLY CONFIDENTIAL

********** HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS? ***********

Cardiovascular

Congestive heart failure	YES	NO
Heart attack	YES	NO
Angina or chest	YES	NO
High blood pressure	YES	NO
Heart Murmur	YES	NO
Mitral valve prolapse	YES	NO
Rheumatic fever	YES	NO
Congenital heart defect	YES	NO
Artificial heart valve	YES	NO
Pacemaker/defibrillator	YES	NO
Coronary Bypass	YES	NO
Heart transplant	YES	NO
Other heart problems	YES	NO

Neurological

Vision problems	YES	NO
Glaucoma	YES	NO
Hearing loss	YES	NO
Severe headaches	YES	NO
Fainting/Dizzy spells	YES	NO
Stroke	YES	NO
Epilepsy, convulsions, or seizures	YES	NO
Psychiatric treatment	YES	NO
Panic attacks	YES	NO
Phobias	YES	NO

Pulmonary

Hay fever	YES	NO
Sinus troubles	YES	NO
Allergies	YES	NO
Emphysema	YES	NO
Chronic bronchitis	YES	NO
Tuberculosis	YES	NO
Asthma	YES	NO
Shortness of Breath	YES	NO

Musculoskeletal

Arthritis	YES	NO
Artificial joints	YES	NO
Date of placement_____		
Systemic lupus	YES	NO

Hematologic

Blood transfusion	YES	NO
Anemia	YES	NO
Hemophilia	YES	NO
Leukemia	YES	NO
Sickle cell anemia	YES	NO
Excessive bleeding	YES	NO
Clotting disorder	YES	NO

Gastrointestinal

Stomach/Intestinal Ulcers	YES	NO
Colitis	YES	NO
Hepatitis	YES	NO
Liver disease	YES	NO
Cirrhosis	YES	NO
Eating disorder	YES	NO

Endocrine

Diabetes	YES	NO
Thyroid disease	YES	NO
Taking cortisone/steroids	YES	NO

Genitourinary

Kidney/Bladder infection	YES	NO
Dialysis	YES	NO
Kidney transplant	YES	NO
STD	YES	NO

Malignancies

Cancer	YES	NO
Radiation therapy	YES	NO
Chemotherapy	YES	NO

Substance abuse

Use of tobacco	YES	NO
If yes, how much? _____		
Drug or alcohol addiction	YES	NO

Women Only

Are you Pregnant?	YES	NO
Nursing?	YES	NO
Taking birth control pills?	YES	NO

Have you lost 10 or more pounds in the last 6 months without dieting? YES NO

The information about my health history is accurate to best of my knowledge

Signature of patient, parent or guardian _____ Date _____

Reviewed by doctor _____ Date _____

DFW Sleep Solutions

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (insurance carrier, etc.);
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Below are the DOCTORS/family members/other individuals that I permit disclosure of my dental health, treatment, etc.

_____

_____

_____

_____

_____
Patient Printed Name

_____ _____
Signature of patient (if minor, parental guardian) Date

_____ _____
Witness Date

Corinth Location
3941 FM 2181
Corinth, Texas 76210

DFW Sleep Solutions
(940) 312-6939 (Office)
(940) 205-5010 (Fax)

Plano Location
7000 W. Plano Pkwy
Suite 205
Plano, TX 75093

Name:_____ Date: _____

Have you ever been given a CPAP device?	Y _____	N
If you have been given a CPAP device, do you use it every night?	Y _____	N
Are you comfortable with your CPAP and satisfied with its use?	Y _____	N

PART 1 : Epworth Sleepiness Scale

How likely, are you to doze off while doing the following activities? Please use the following scale: 0= Never, 1= Slight, 2= Moderate, 3= High. Circle one of the following numbers.

Being a passenger in a motor vehicle for an hour or more ……	0 1 2 3
Sitting and talking to someone……	0 1 2 3
Sitting and reading……	0 1 2 3
Watching TV……..	0 1 2 3
Sitting inactive in a public place……..	0 1 2 3
Lying down to rest in the afternoon……	0 1 2 3
Sitting quietly after lunch without alcohol…….	0 1 2 3
In a car, while stopped for few minutes in traffic……..	0 1 2 3

Total: **Score of 8 or more = 1 diagnostic point.**

PART 2: Every Yes = 1 diagnostic point.

Have you ever been told you snore?	☐ Y	☐ N
Do you wake up choking or gasping?	☐ Y	☐ N
Have you had high blood pressure?	☐ Y	☐ N
Do you have diabetes?	☐ Y	☐ N
Have you ever experienced an irregular heart rhythm?	☐ Y	☐ N

PART 3: Every Yes = 1 diagnostic point.

Does snoring cause any problems at home?	☐ Y	☐ N
Would you like to fix that? (If yes to above question)	☐ Y	☐ N

Signature _____ Date _____

PART 4: (By Assistant)

Blood Pressure _____ Pulse_____

Neck Size_____(**Excessive Neck of size (Female >15, Male > 16.5) = 1 diagnostic point)**

Height_____Weight_____BMI_____(**BMI > 30 = 1 diagnostic Point)**

Mallampati_____**(Class III or IV Greater = 1 diagnostic point)**

Scalloped Tongue_____(Scalloped tongue = 1 diagnostic point)_____Schedule telemedicine Visit