AmieSpurlock
Sleep Systems for Success

OSA New Patient Intake

Appointment Date: \ \	Appointment Time:
Patient Information	**Insurance Information**
Patient Name:	Primay Ins:
Cell #:	ID#:
Work #:	Group #:
Home #:	Ins Phone #:
Email:	Subscriber Name:
DOB:	Subscriber DOB:
SSN:	Other Insurance Name:
Sex:	Other Insurance ID:
Street Address:	Other Insurance Group #:
City, State, Zip:	Other Insurance Ph #:
Referral Source:	Subscriber Name:
Patient's main concern?	Subscriber DOB:
Additional Information	
Have you had a sleep study? Yes | No	If yes, when?
What location was your sleept study done at?	
Have you been diagnosed with OSA? Yes | No	If yes, when?
If yes, what type of treatment have you tried? CPCP | BIPAP | OAT | Surgery	
Do you wear partials or dentures: Yes | No	
Height:	Weight:
Physician Contact Information	
Dentist Name:	Number:
Sleep Physician Name:	Number:
PCP Name:	Number:
Referring Physican Name:	Number:
For Office Use	
NP Paperwork sent via:	Med Ins VOI Date:
PSG requested: Yes | No	PSG Requested Date and Time:
Today's Date: \ \	Team Member:

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Sleep Screening Questionnaire

Patient Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Epworth Sleepiness Scale

Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

Use the following scale to select the most appropriate number for each situation.

0 = I would never doze

1 = I have a slight chance of dozing

3 = I have a moderate chance of dozing

4 = I have a high chance of dozing

	Situation	
1	Sitting and reading	
2	Watching TV	
3	Sitting inactive in a public place (e.g. a theatre or a meeting)	
4	As a passenger in a car for an hour without a break	
5	Lying down to rest in the afternoon when circumstances permit	
6	Sitting and talking to someone	
7	Sitting quietly after lunch without alcohol	
8	In a car while stopped for a few minutes in traffic	
	Total:	

Dentrix Tips for Supporting a DSM Practice

1. Store all documents in the Document Center and create DSM specific folders.
2. Utilize Bill Types to separate DSM patients.
3. Create separate dental and DSM accounts for the patient.
4. Take advantage of paperless forms with integrated Dentrix partners.
5. If you have Oulook, use the desktop version to efficiently email documents.
6. Use Continuing Care to setup a DSM type.
7. Build Custom Letters.

Questionnaires You Can Utilize

- Berlin Questionnaire
- STOP-Bang Questionnaire
- STOP Questionnaire
- Epworth Sleepiness Scale
- Bed Partner Questionnaire

Additional Questions for the Health History

1. Have you been told or have you noticed you snore most nights?
2. Have you been told or have you noticed on your own that you stop breathing or struggle to breathe in your sleep?
3. Have you been told or noticed you wake up choking or gasping for air?
4. Have you been diagnosed with sleep apnea?
5. If yes, do you currently wear a CPAP, BIPAP, or oral appliance to manage your sleep apnea or snoring?
6. Are you tired, fatigued, or sleepy most days?