



### Sleep Better Abingdon - New Patient Form

Please complete the following or go to:

<https://www.dentalregistration.com/AnonymousEntry.aspx?PFID=21337>

#### 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

Dental Sleep Solutions® 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: \_\_\_\_\_



## Sleep Better Abingdon Patient Questionnaire

### 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 \_\_\_\_\_

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

TOTAL = \_\_\_\_\_

### 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 people when I am sleeping away from home \_\_\_\_\_

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

TOTAL = \_\_\_\_\_

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

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#### Do you have other complaints?

- |   |  |
|---|--|
| <input type="checkbox"/> Frequent snoring                               | <input type="checkbox"/> Difficulty maintaining sleep                      |
| <input type="checkbox"/> Excessive Daytime Sleepiness (EDS)             | <input type="checkbox"/> Choking while sleeping                            |
| <input type="checkbox"/> Difficulty falling asleep                      | <input type="checkbox"/> Feeling unrefreshed in the morning                |
| <input type="checkbox"/> Waking up gasping / choking                    | <input type="checkbox"/> Memory problems                                   |
| <input type="checkbox"/> Morning headaches                              | <input type="checkbox"/> Impotence   |
| <input type="checkbox"/> Neck or facial pain                            | <input type="checkbox"/> Nasal problems, difficulty breathing through nose |
| <input type="checkbox"/> I have been told I stop breathing when I sleep | <input type="checkbox"/> Irritability or mood swings                       |
| <input type="checkbox"/> Other: _____                                   |  |

### Subjective Signs and Symptoms

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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





## Sleep Better Abingdon Patient Questionnaire

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? \_\_\_\_\_ / 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?

- |  |  |
|--|--|
| <input type="checkbox"/> Mask leaks  | <input type="checkbox"/> Device causes claustrophobia or panic attacks |
| <input type="checkbox"/> An inability to get the mask to fit properly                          | <input type="checkbox"/> An unconscious need to remove CPAP at night   |
| <input type="checkbox"/> Discomfort from the straps or headgear                                | <input type="checkbox"/> Caused GI / stomach / intestinal problems     |
| <input type="checkbox"/> Decrease sleep quality or interrupted sleep from CPAP device          | <input type="checkbox"/> CPAP device irritated my nasal passages       |
| <input type="checkbox"/> Noise from the device disrupting sleep and/or bedtime partner's sleep | <input type="checkbox"/> Inability to wear due to nasal problems       |
| <input type="checkbox"/> CPAP restricted movement during sleep                                 | <input type="checkbox"/> Causes dry nose or dry mouth                  |
| <input type="checkbox"/> CPAP seems to be ineffective  | <input type="checkbox"/> The device causes irritation due to air leaks |
| <input type="checkbox"/> Device causes teeth or jaw problems                                   | <input type="checkbox"/> Other: _____                                  |
| <input type="checkbox"/> A latex allergy   | _____  |

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:

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Sleep Better Abingdon Patient Questionnaire

**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? \_\_\_\_\_

### PATIENT SIGNATURE

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: \_\_\_\_\_