SAN FRANCISCO CENTER FOR TMJ AND SLEEP APNEA

GREG D. LARSON, DDS, FAACP, AGDF

(415) 872-5116

MRS/MS/MR/DR _____
LAST, FIRST, MIDDLE

HOME ADDRESS _____
STREET, CITY, STATE, ZIP

BUSINESS ADDRESS _____
STREET, CITY, STATE, ZIP

BILLING ADDRESS _____
STREET, CITY, STATE, ZIP

EMAIL ADDRESS _____

TELEPHONE NUMBERS _____
HOME BUSINESS CELLULAR

DATE OF BIRTH _____ SS# _____

EMPLOYER _____ OCCUPATION _____

DENTAL INSURANCE CARRIER, PLAN #, GROUP #: _____

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MEDICAL INSURANCE CARRIER, PLAN #, GROUP #: _____

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

PARENT OR GUARDIAN, IF PATIENT IS A MINOR _____

PERSON TO CONTACT IN EMERGENCY _____ RELATIONSHIP _____ PH# _____

REFERRED BY: ____ DDS ____ MD ____ ENT ____ DC

REASON FOR THIS APPOINTMENT: ____ PAIN ____ SLEEP ____ BREATHING ____ ORTHODONTICS____ OTHER

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?
NOTE – PLEASE MARK RECENT OR CHRONIC (6+MO) AND PLEASE PRIORITIZE YOUR COMPLAINTS #1-9.

R C _____HEADACHE PAIN
R C _____EAR PAIN
R C _____JAW PAIN
R C _____PAIN WHEN CHEWING
R C _____FACIAL PAIN
R C _____EYE PAIN
R C _____THROAT PAIN
R C _____NECK PAIN
R C _____SHOULDER PAIN
R C _____BACK PAIN
R C _____LIMITED ABILITY TO OPEN MOUTH
R C _____JAW JOINT LOCKING
R C _____JAW JOINT NOISES
R C _____EAR CONGESTION
R C _____SINUS CONGESTION
R C _____DIZZINESS
R C _____TINNITUS (RINGING IN THE EARS)
R C _____MUSCLE TWITCHING
R C _____VISION PROBLEMS

R C _____RESTLESS LEGS DURING SLEEP
R C _____SWELLING IN ANKLES OR FEET
R C _____MORNING HOARSENESS
R C _____DRY MOUTH UPON WAKING
R C _____FATIGUE
R C _____DIFFICULTY FALLING ASLEEP
R C _____TOSSING AND TURNING FREQUENTLY
R C _____REPEATED AWAKENING
R C _____FEELING UN-REFRESHED IN THE MORNING
R C _____SIGNIFICANT DAYTIME DROWSINESS
R C _____FREQUENT HEAVY SNORING
R C _____AFFECTS SLEEP OF OTHERS
R C _____GASPING WHEN WAKING
R C _____TOLD THAT "I STOP BREATHING" DURING SLEEP
R C _____NIGHT-TIME CHOKING SPELLS
R C _____UNABLE TO TOLERATE C-PAP
R C _____TOOTH GRINDING
R C _____TEETH CROWDING
R C _____OTHER_____

DO YOU HAVE CONCERNS IN ANY OF THESE AREAS: _____

☐ GENERAL APPEARANCE ☐ ABILITY TO FUNCTION ☐ OVERBITE ☐ SMILE ☐ OTHER _____

DO ANY OF THE ABOVE COMPLAINTS OR CONCERNS AFFECT YOUR DAILY LIFE? ☐ YES ☐ NO

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT? _____

ALLERGIC REACTIONS : PLEASE CHECK ANY AND ALL MEDICATIONS OR SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION

☐ ANESTHETICS ☐ ANTIBIOTICS ☐ ASPIRIN ☐ BARBITURATES ☐ CODEINE ☐ IODINE ☐ LATEX ☐ METALS

☐ PENICILLIN ☐ PLASTIC ☐ SULFA ☐ OTHER _____

CURRENT MEDICATIONS : PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND THE REASON YOU TAKE THEM. INCLUDE ALL OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBS, ETC.

MEDICATION	DOSAGE	REASON FOR TAKING

LIST ALL PRIOR TREATMENTS/MEDICATIONS : FOR THE CONDITION WE ARE EVALUATING

TREATMENT AND/OR MEDICATION	DOCTOR/PROVIDER NAME	APPROXIMATE DATE OF TREATMENT

PATIENT SIGNATURE: _____ DATE:_____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR):_____

HEALTH AND MEDICAL HISTORY

☐ YES ☐ NO ARE YOU CURRENTLY PREGNANT?

☐ YES ☐ NO HAVE YOU SUSTAINED INJURY TO

☐ HEAD ☐ NECK ☐ TEETH ☐ OTHER: _____

☐ YES ☐ NO DO YOU DRINK 4 OR MORE CUPS OF COFFEE/ CAFFEINATED TEA PER DAY?

☐ YES ☐ NO DO YOU SMOKE TOBACCO?

☐ YES ☐ NO DO YOU CONSUME ALCOHOL

☐ YES ☐ NO DO YOU TAKE SEDATIVES FOR PAIN RELIEF OR SLEEP?

☐ YES ☐ NO HAVE YOU HAD ORTHODONTICS/BRACES?

☐ YES ☐ NO TROUBLE BREATHING

DO YOU HAVE, OR HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

☐ YES ☐ NO HEART DISORDER/ HEART ATTACK

☐ YES ☐ NO HEART MURMUR

☐ YES ☐ NO MITRAL VALVE PROLAPSE

☐ YES ☐ NO HEART PACEMAKER

☐ YES ☐ NO HEART PALPITATIONS

☐ YES ☐ NO HEART VALVE REPLACEMENT

☐ YES ☐ NO IRREGULAR HEARTBEAT

☐ YES ☐ NO BLOOD PRESSURE HIGH LOW

☐ YES ☐ NO STROKE

☐ YES ☐ NO BLEEDING EASILY

☐ YES ☐ NO BRUISING EASILY

☐ YES ☐ NO CANCER OF: _____ ☐ CHEMO ☐ RADIATION

☐ YES ☐ NO ANEMIA

☐ YES ☐ NO ASTHMA

☐ YES ☐ NO BIRTH DEFECTS

☐ YES ☐ NO DIABETES

☐ YES ☐ NO EPILEPSY

☐ YES ☐ NO EMPHYSEMA

☐ YES ☐ NO GLAUCOMA

☐ YES ☐ NO GASTROESOPHAGEAL REFLUX (GERD)

☐ YES ☐ NO HEMOPHILIA

☐ YES ☐ NO HEPATITIS

☐ YES ☐ NO HISTORY OF SUBSTANCE ABUSE

☐ YES ☐ NO HYPOGLYCEMIA

☐ YES ☐ NO HUNTINGTON'S DISEASE

☐ YES ☐ NO KIDNEY DISEASE

☐ YES ☐ NO LIVER DISEASE

☐ YES ☐ NO LEUKEMIA

☐ YES ☐ NO MIGRAINES

☐ YES ☐ NO MENIERE'S DISEASE

☐ YES ☐ NO MULTIPLE SCLEROSIS

☐ YES ☐ NO MUSCULAR DYSTROPHY

☐ YES ☐ NO NEURALGIA

☐ YES ☐ NO OSTEOARTHRITIS

☐ YES ☐ NO OSTEOPOROSIS

☐ YES ☐ NO OVARIAN CYST

☐ YES ☐ NO PARKINSON'S DISEASE

☐ YES ☐ NO RHEUMATIC FEVER

☐ YES ☐ NO RHEUMATOID ARTHRITIS

☐ YES ☐ NO SCARLET FEVER

☐ YES ☐ NO THYROID PROBLEM

☐ YES ☐ NO TUBERCULOSIS

☐ YES ☐ NO INTESTINAL DISORDER

☐ YES ☐ NO NERVOUS SYSTEM DISORDER

☐ YES ☐ NO ANXIETY

☐ YES ☐ NO SKIN DISORDER

☐ YES ☐ NO URINARY TRACT DISORDER

☐ YES ☐ NO CHRONIC FATIGUE

☐ YES ☐ NO FIBROMYALGIA

☐ YES ☐ NO COLD HANDS AND FEET

☐ YES ☐ NO DEPRESSION

☐ YES ☐ NO DIFFICULTY CONCENTRATING

☐ YES ☐ NO DIZZINESS

☐ YES ☐ NO EXCESSIVE THIRST

☐ YES ☐ NO FAINTING

☐ YES ☐ NO FLUID RETENTION

☐ YES ☐ NO FREQUENT COLDS/FLU

☐ YES ☐ NO FREQUENT COUGH

☐ YES ☐ NO FREQUENT EAR INFECTIONS

☐ YES ☐ NO FREQUENT SORE THROATS

☐ YES ☐ NO FREQUENT AWAKING AT NIGHT ___NUMBER OF TIMES:

☐ YES ☐ NO HEARING IMPAIRMENT

☐ YES ☐ NO MEMORY LOSS

☐ YES ☐ NO HAY FEVER

☐ YES ☐ NO INSOMNIA

☐ YES ☐ NO MUSCLE ACHES

☐ YES ☐ NO MUSCLE FATIGUE

☐ YES ☐ NO MUSCLE SPASMS

☐ YES ☐ NO MUSCLE TREMORS

☐ YES ☐ NO POOR CIRCULATION

☐ YES ☐ NO PSYCHIATRIC CARE

☐ YES ☐ NO RECENT WEIGHT GAIN

☐ YES ☐ NO RECENT WEIGHT LOSS

☐ YES ☐ NO SINUS PROBLEMS

☐ YES ☐ NO SHORTNESS OF BREATH

☐ YES ☐ NO SLOW HEALING SORES

☐ YES ☐ NO SPEECH DIFFICULTIES

☐ YES ☐ NO SWOLLEN, STIFF OR PAINFUL JOINTS

☐ YES ☐ NO TIRED MUSCLES

ADDITIONAL INFORMATION: _____

SURGICAL HISTORY HAVE YOU HAD ANY OF THE FOLLOWING:

☐ YES ☐ NO GENERAL ANESTHESIA

☐ YES ☐ NO ADENOIDS REMOVED

☐ YES ☐ NO TONSILS REMOVED

☐ YES ☐ NO JAW JOINT SURGERY

☐ YES ☐ NO ORTHOGNATHIC SURGERY

☐ YES ☐ NO ORAL SURGERY

☐ REMOVAL OF THIRD MOLAR (WISDOM TEETH) ☐ OTHER

☐ YES ☐ NO OTHER SURGERY: PLEASE LIST BELOW

OTHER TYPES OF SURGERY: _____

PATIENT SIGNATURE: _____

PRESENT SYMPTOMS
HEAD PAIN LOCATION L = LEFT R = RIGHT B = BILATERAL

LOCATION		CHRONIC (OVER 6 MO.)	FREQUENCY			SEVERITY			DURATION		
			OCCASIONAL	FREQUENT	CONSTANT	MILD	MOD	SEVERE	MIN.	HRS.	DAYS
☐L ☐R ☐B TEMPORAL (TEMPLE AREA)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐L ☐R ☐B FRONTAL (FOREHEAD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐L ☐R ☐B OCCIPITAL (BACK OF HEAD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐L ☐R ☐B PARIETAL (TOP OF HEAD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐L ☐R ☐B GENERALIZED	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

DO YOU HAVE PAIN OR DISCOMFORT IN ANY OF THE FOLLOWING AREAS? IF SO, PLEASE INDICATE THE APPROXIMATE DATE THE PAIN BEGAN.

JAW PAIN

☐ L ☐ R JAW PAIN WITH OPENING
☐ L ☐ R JAW PAIN WHEN CHEWING
☐ L ☐ R JAW PAIN AT REST

JAW JOINT SOUNDS

☐ L ☐ R JAW SOUNDS WITH OPENING
☐ L ☐ R JAW SOUNDS WHEN CHEWING
☐ L ☐ R JAW SOUNDS AT REST

JAW LOCKING

☐ Y ☐ N JAW LOCKS CLOSED
☐ Y ☐ N JAW LOCKS OPEN

JOINT SYMPTOMS

☐ Y ☐ N TEETH CLENCHING ☐DAY ☐NIGHT
☐ Y ☐ N TEETH GRINDING ☐DAY ☐NIGHT

EYE RELATED CONDITIONS

☐ Y ☐ N BLURRED VISION
☐ Y ☐ N DOUBLE VISION
☐ Y ☐ N EYE PAIN
☐ Y ☐ N PAIN OR PRESSURE BEHIND THE EYES
☐ Y ☐ N EXTREME SENSITIVITY TO LIGHT (PHOTOPHOBIA)
☐ Y ☐ N WEAR OF GLASSES OR CONTACT LENSES

EAR RELATED CONDITIONS

☐ L ☐ R RINGING IN THE EAR (TINNITUS)
☐ L ☐ R BUZZING IN THE EARS
☐ L ☐ R EAR CONGESTION
☐ L ☐ R EAR PAIN
☐ L ☐ R HEARING LOSS
☐ L ☐ R ITCHINESS OR STUFFINESS IN EARS
☐ L ☐ R PAIN BEHIND THE EAR
☐ L ☐ R PAIN IN FRONT OF THE EAR
☐ L ☐ R RECURRENT EAR INFECTIONS

THROAT RELATED CONDITIONS

☐ Y ☐ N CHRONIC SORE THROAT
☐ Y ☐ N DIFFICULTY SWALLOWING
☐ Y ☐ N SWOLLEN GLANDS
☐ Y ☐ N THYROID ENLARGEMENT
☐ Y ☐ N TIGHTNESS IN THROAT
☐ Y ☐ N CONSTANT FEELING OF FOREIGN OBJECT IN THROAT

NECK RELATED CONDITIONS

☐ Y ☐ N LIMITED MOVEMENT OF NECK
☐ Y ☐ N NECK PAIN
☐ Y ☐ N NUMBNESS IN HANDS OR FINGERS
☐ Y ☐ N SWELLING IN THE NECK

DO YOU SUFFER FROM HEADACHES / MIGRAINES? – CIRCLE ONE OR BOTH
HOW OFTEN? DAILY, ____ TIMES A WEEK, ____TIMES A MONTH

PATIENT SIGNATURE: _____ DATE: _____

SHOULDER RELATED CONDITIONS

☐ Y ☐ N SHOULDER PAIN
☐ Y ☐ N SHOULDER STIFFNESS
☐ Y ☐ N TINGLING IN HANDS OR FINGER

BACK RELATED CONDITIONS

☐ Y ☐ N BACK PAIN - LOWER
☐ Y ☐ N BACK PAIN - MIDDLE
☐ Y ☐ N BACK PAIN - UPPER
☐ Y ☐ N SCIATICA
☐ Y ☐ N SCOLIOSIS

MOUTH AND NOSE RELATED CONDITIONS

☐ Y ☐ N DRY MOUTH
☐ Y ☐ N CHRONIC SINUSITIS
☐ Y ☐ N FREQUENT SNORING
☐ Y ☐ N BURNING TONGUE
☐ Y ☐ N FREQUENT BITING OF THE CHEEK

PLEASE SELECT YES OR NO BASED ON YOUR AVERAGE SLEEP EXPERIENCE AND/OR WHAT A SLEEP PARTNER HAS TOLD YOU

SLEEP POSITIONS ☐ SIDE ☐ BACK ☐ STOMACH ☐ VARIES
IS IT EASY TO FALL ASLEEP? ☐ YES ☐ NO
DO YOU FEEL RESTED UPON AM WAKING? ☐ YES ☐ NO
STOPPED BREATHING DURING SLEEP? ☐ YES ☐ NO AVERAGE
HOURS OF SLEEP PER NIGHT: _____
DO YOU WAKE OFTEN DURING THE NIGHT? ☐ YES ☐ NO
GASPING OR CHOKING DURING SLEEP? ☐ YES ☐ NO
HAVE YOU EVER HAD A SLEEP STUDY (PSG)? ☐ YES ☐ NO
RESULT WAS: _____

_____

HISTORY OF SYMPTOMS
ON WHAT DATE, OR APPROXIMATE DATE, DID THIS CONDITION OR SYMPTOMS FIRST OCCUR? _____
☐ YES ☐ NO DOES ANY FAMILY MEMBER HAVE THE SAME OR SIMILAR PROBLEM? IF YES, PLEASE EXPLAIN:

_____

CAN YOU RELATE YOU PAIN OR CONDITION TO A MOTOR VEHICLE ACCIDENT OR TRAUMATIC INJURY? _____
IF YES, PLEASE EXPLAIN.

I AUTHORIZE THE RELEASE OF ALL EXAMINATION FINDINGS AND DIAGNOSIS, REPORT AND TREATMENT PLANS, ETC., TO ANY REFERRING OR TREATING HEALTH CARE PROVIDER. I ADDITIONALLY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO INSURANCE COMPANIES, OR FOR LEGAL DOCUMENTATION TO PROCESS CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR MY TREATMENT REGARDLESS OF INSURANCE COVERAGE.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR): _____ DATE: _____

DENTAL HISTORY

WHEN WAS YOUR LAST DENTAL VISIT? _____

☐ YES ☐ NO HAVE YOU BEEN TOLD THAT YOU HAVE PERIODONTAL (GUM) DISEASE?
☐ YES ☐ NO DO YOU HAVE ANY EXISTING PROBLEMS WITH YOUR TEETH? DESCRIBE: _____
☐ YES ☐ NO IS ANY DENTAL TREATMENT PLANNED? DESCRIBE: _____
☐ YES ☐ NO DO YOU BITE YOUR NAILS?
☐ YES ☐ NO HAVE YOU EVER HAD ORAL SURGERY?
☐ YES ☐ NO HAVE YOU LOST ANY TEETH? FROM WHAT CAUSE: _____
☐ YES ☐ NO HAVE YOUR TEETH BEEN REPLACED?
☐ YES ☐ NO HAVE YOU EVER HAD ORTHODONTIC TREATMENT? WHEN: _____
☐ YES ☐ NO HAVE YOU EVER HAD EXTENSIVE DENTAL TREATMENT? WHEN: _____
☐ YES ☐ NO IS ANY PART OF YOUR MOUTH SENSITIVE TO TEMPERATURE, PRESSURE, FOOD OR DRINK? WHERE: _____
_____
☐ YES ☐ NO DO YOU WEAR DENTURES OR PARTIALS? ARE THEY COMFORTABLE? _____

TMJ HISTORY

☐ YES ☐ NO DO YOU EVER HAVE A BURNING OR PAINFUL SENSATION IN YOUR MOUTH?
☐ YES ☐ NO DO YOU GET POPPING, CLICKING, OR GRINDING NOISES WHEN YOU OPEN OR CLOSE YOU MOUTH?
☐ YES ☐ NO DO YOU EVER AWAKEN WITH AN AWARENESS OF YOUR TEETH OR JAWS?
☐ YES ☐ NO ARE YOU AWARE OF CLENCHING DURING THE DAYTIME? HOW OFTEN: _____
☐ YES ☐ NO HAVE YOU EVER BEEN TOLD YOUR GRIND YOUR TEETH DURING SLEEP?
☐ YES ☐ NO DO YOU HAVE TROUBLE OPENING YOUR MOUTH WIDELY?
☐ YES ☐ NO DOES YOUR JAW EVER LOCK OPENED OR CLOSED? HOW OFTEN:
☐ YES ☐ NO DO YOU FEEL YOUR BITE IS DIFFERENT, UNSTABLE OR UNCOMFORTABLE?
WHAT PROFESSIONAL ADVICE OR TREATMENT HAVE YOU HAD REGARDING YOUR TMJ, HEADACHES OR PAIN CONDITIONS/PROBLEMS? _____
☐ YES ☐ NO IF YOU SOUGHT TREATMENT FOR A TMJ PROBLEM, DID IT HELP?
☐ YES ☐ NO DO YOU OR HAVE YOU HAD ANY PAIN IN ANY OF THE FOLLOWING AREAS? (CIRCLE)
JAW EAR FACE NECK TEETH HEAD OTHER:
☐ YES ☐ NO DO YOUR JAW PROBLEMS AFFECT YOUR ABILITY TO CHEW?
☐ YES ☐ NO HAS YOUR DIET CHANGED DUE TO YOUR JAW PROBLEMS? DESCRIBE: _____
☐ YES ☐ NO DO YOUR JOINT NOISES AFFECT OTHERS WHILE EATING OR SLEEPING?

SLEEP, SNORING AND APNEA HISTORY

☐ YES ☐ NO DO YOU BECOME EASILY FATIGUED? AT WHAT TIME OF DAY? _____
☐ YES ☐ NO DO YOU HAVE PROBLEMS WITH INSOMNIA?
☐ YES ☐ NO DO YOU SLEEP WELL? HOW LONG: _____
☐ YES ☐ NO DO YOU DREAM? HOW OFTEN: _____
☐ YES ☐ NO DO YOU HAVE TROUBLE FALLING ASLEEP OR STAYING ASLEEP? WHICH: _____
☐ YES ☐ NO DO YOU SNORE OR HAVE YOU BEEN TOLD THAT YOU DO?
☐ YES ☐ NO DO YOU WAKE UP WITH A HEADACHE?
☐ YES ☐ NO HAVE YOU HAD CHRONIC SLEEPINESS, FATIGUE OR WEARINESS THAT YOU CAN'T EXPLAIN?
☐ YES ☐ NO DO YOU OFTEN FALL ASLEEP READING OR WATCHING TELEVISION?
☐ YES ☐ NO HAVE YOU FALLEN ASLEEP DURING THE DAY AGAINST YOUR WILL?
☐ YES ☐ NO HAVE YOU HAD TO PULL OFF THE ROAD WHILE DRIVING DUE TO SLEEPINESS?
☐ YES ☐ NO HAVE YOU BEEN MORE IRRITABLE AND SHORT TEMPERED?
☐ YES ☐ NO HAVE YOU FELT THAT YOUR MEMORY AND/OR INTELLECT ARE IMPAIRED?
☐ YES ☐ NO HAVE BEEN TOLD THAT YOU STOP BREATHING WHILE ASLEEP?

ABOUT HOW MANY TIMES PER NIGHT DO YOU WAKE UP? _____

WHAT TIME DO YOU NORMALLY GO TO BED: _____ GET UP IN THE MORNING: _____
OF THE HOURS YOU ARE IN BED, ABOUT HOW MANY HOURS DO YOU SLEEP? _____
WOULD YOU RATE THE QUALITY OF SLEEP AS ☐ GOOD ☐ FAIR ☐ POOR?

☐ YES ☐ NO DO YOU HAVE DIFFICULTY BREATHING THROUGH YOUR NOSE?
☐ YES ☐ NO HAVE YOU BEEN DIAGNOSED OR TREATED FOR A SLEEP DISORDER? WHEN:
☐ YES ☐ NO HAVE ANY IMMEDIATE FAMILY MEMBERS BEEN DIAGNOSED OR TREATED FOR A SLEEP DISORDER?
☐ YES ☐ NO HAVE YOU EVER HAD AN EVALUATION AT A SLEEP CENTER?
SLEEP CENTER NAME: _____
LOCATION: _____
SLEEP STUDY DATE: _____

WHAT PROFESSIONAL ADVICE OR TREATMENT HAVE YOU RECEIVED ABOUT YOUR SNORING OR APNEA? _____
☐ YES ☐ NO IF YOU SOUGHT TREATMENT FOR A SLEEP DISORDER, DID IT HELP?

I CERTIFY HAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____

IF YOU HAVE NEVER WORN A CPAP DEVICE, SKIP THIS SECTION AND TURN THE PAGE!

CPAP HISTORY:

☐ YES ☐ NO DO YOU WEAR A CPAP DEVICE SUCCESSFULLY DURING SLEEPING?
HOW MANY HOURS PER NIGHT DO YOU WEAR YOUR CPAP?

☐ YES ☐ NO HAVE YOU TRIED OTHER THERAPIES FOR YOUR SLEEPING DISORDER?

PLEASE LIST OTHER THERAPIES (WEIGHT-LOSS ATTEMPTS, SMOKING CESSATION, SURGERIES, ETC.):

IF YOU ARE UNABLE TO WEAR A CPAP DEVICE, PLEASE CHECK BELOW REASONS FOR YOUR DIFFICULTY:

☐ MASK LEAKS
☐ MASK UNCOMFORTABLE/DEVICE UNCOMFORTABLE
☐ UNABLE TO SLEEP COMFORTABLY
☐ NOISE DISTURBS MY SLEEP AND/OR BED PARTNER'S SLEEP
☐ RESTRICTS MOVEMENT DURING SLEEP
☐ DOES NOT SEEM TO BE EFFECTIVE
☐ STRAPS/HEADGEAR CAUSE DISCOMFORT
☐ PRESSURE ON UPPER LIP CAUSES TOOTH RELATED PROBLEMS
☐ LATEX ALLERGY
☐ CLAUSTROPHOBIA
☐ OTHER: _____

_____

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

DAYTIME SLEEPINESS EVALUATION
EPWORTH SLEEPINESS SCALE
THE EPWORTH SLEEPINESS SCALE WAS DEVELOPED AND VALIDATED BY DR. MURRAY JOHNS OF MELBOURNE AUSTRALIA. IT IS A SIMPLE, SELF-ADMINISTERED QUESTIONNAIRE – WIDELY USED BY SLEEP PROFESSIONALS IN QUANTIFYING THE LEVEL OF DAYTIME SLEEPINESS.

USE THE FOLLOWING SCALE AND CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

0 = WOULD NEVER DOZE OFF
1 = SLIGHT CHANCE OF DOZING
2 = MODERATE CHANCE OF DOZING
3 = HIGH CHANCE OF DOZING

SITUATION
SITTING AND READING _____
WATCHING TELEVISION _____
SITTING, INACTIVE IN PUBLIC _____
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 LUNCH WITHOUT ALCOHOL _____
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC _____

TOTAL SCORE _____

NIGHTTIME SLEEPINESS EVALUATION | SCREENING TOOL AND SLEEP APNEA

DEVELOPED BY DAVID WHITE, M.D., HARVARD MEDICAL SCHOOL, BOSTON, MA
PLEASE ANSWER AND SCORE THE FOLLOWING QUESTIONS.

1. SNORING
   A) DO YOU SNORE ON MOST NIGHTS (> 3 NIGHTS PER WEEK)? YES (2) NO (0) _____
   B) IS YOUR SNORING LOUD? CAN IT BE HEARD THROUGH A DOOR OR WALL? YES (2) NO (0) _____

2. HAS IT EVEN BEEN REPORTED TO YOU THAT YOU STOP BREATHING OR GASP DURING SLEEP?
   NEVER (0) OCCASIONALLY (3) FREQUENTLY (5) _____

3. WHAT IS YOUR COLLAR SIZE?
   MALE: LESS THEN 17 INCHES (0) MORE THAN 17 INCHES (5) _____
   WOMEN: LESS THEN 16 INCHES (0) MORE THEN 16 INCHES (5) _____

4. DO YOU OCCASIONALLY FALL ASLEEP DURING THE DAY WHEN:
   A) YOU ARE BUSY OR ACTIVE? YES (2) NO (0) _____

   B) YOU ARE DRIVING OR STOPPED AT A LIGHT? YES (2) NO (0) _____

5. HAVE YOU HAD OR ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE? YES (1) NO (0) _____

TOTAL _____

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

PATIENT SIGNATURE: _____ DATE: _____

CONSENT FOR TREATMENT:

I hereby authorize Greg D. Larson, DDS and designated staff to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize Greg D. Larson, DDS and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care. I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the clinic

I agree to the use of anesthetics, sedatives and other medications as necessary to my treatment protocol. I fully understand that using anesthetics embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of full report examination findings, diagnosis, treatment program and ongoing process reports to any referring dentist, physician, chiropractor or other health care professionals as indicated. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

OFFICE FINANCIAL AND INSURANCE POLICIES:

We endeavor to bring our patients leading edge technologies, and treatment modalities and the most gifted auxiliary team in a comfortable and relaxing environment.

In order to provide this high level of TMD and Sleep Breathing Disorder treatment we request our patients pay cost of treatment at the time of their visit. We accept all major credit cards, cash, check and 3rd party outside financing servicing is available.

OFFICE CANCELLATION POLICY:

We pride ourselves in providing extra time for the personal attention each of our patients deserves. Your appointment time in this office will be reserved exclusively for you. We do not "double book" our patients, in respect of your time constraints.

We request you provide us with at least forty-eight business hours' notice (Business hours are Monday through Thursday) if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointment with adequate notice, or who fail to keep their scheduled appointments an appropriate cancellation fee.

NEW CALIFORNIA REGULATIONS:
The State of California now requires each dental office to make available to their patient A document called THE 'dental materials fact sheet". This document outlines various types of materials used in dental environment. This document is available to each of our patients in each treatment room and reception desk or on the web: www.dentalwatch.org/basic/dentalfactsheet.pdf.

I AGREE TO THE ABOVE PARAMETERS. A COPY OF THE DMF'S HAS BEEN MADE AVAILABLE TO ME

PATIENT SIGNATURE: _____ DATE: _____

TO BETTER COORDINATE YOUR TREATMENT, PLEASE LIST THE PROFESSIONALS YOU HAVE CONSULTED REGARDING YOUR PRESENT SYMPTOMS. PLEASE BE SURE TO LIST YOUR PRIMARY PHYSICIAN AND FAMILY DENTIST. PLEASE INITIAL IF YOU WANT US TO SEND THEM A REPORT FROM YOUR VISIT.

Family Physician Initial
Name
Address
Phone

Dentist Initial
Name
Address
Phone

Chiropractor Initial
Name
Address
Phone

Physical Therapist Initial
Name
Address
Phone

ENT Initial
Name
Address
Phone

Cardiologist Initial
Name
Address
Phone

Allergist Initial
Name
Address
Phone

Neurologist Initial
Name
Address
Phone

Psychiatrist Initial
Name
Address
Phone

Psychologist Initial
Name
Address
Phone

Sleep Specialist Initial
Name
Address
Phone

Other Initial
Name
Address
Phone

☐ I UNDERSTAND AND AGREE TO HAVE THE INDICATED PROFESSIONALS I HAVE LISTED ABOVE BE SENT INITIAL INFORMATION AND ONGOING UPDATES REGARDING MY DIAGNOSES AND TREATMENT.

☐ I DO NOT WISH TO HAVE MY RECORDS SENT AT THIS TIME.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____