

South Carolina Dental Sleep Center LLC

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Patient Personal Information

Form with fields for Patient Personal Information: Title, Preferred Name, Birth Date, Age, Last, First, Marital Status, Sex, Address, Home #, Work #, Cell #, Drive Lic, City, State, Zip, Emergency Contact, Emergency Phone #, Email, Student, SSN, Health Care Guardian Name, School Name, Health Care Guardian Phone #, Referral Type.

Person responsible/guarantor for paying bills

Form with fields for Person responsible/guarantor for paying bills: Title, Preferred Name, Birth Date, Age, Last, First, Marital Status, Sex, Address, Home #, Work #, Cell #, Drive Lic, City, State, Zip, SSN, Email.

Do you have Primary Dental Insurance? Yes No Do you have Secondary Dental Insurance? Yes No

Form with fields for Primary and Secondary Dental Insurance: Group No/Name, Insurance Name, Phone #, Employer Name, Subscriber Last, First, Subscriber Address, City, State, Zip, Relationship to Patient, Birth Date, Subscriber ID.

Patient Medical Information

Form with medical information sections: Im Seeking Treatment Because, Heart Related, Breathing Related, Immune Related, Bone Related, Other Systems, Cancer, Pregnancy Related. Includes checkboxes for various conditions like Asthma, Diabetes, Cancer, etc.

Additional Comments

Dental Questionnaire

Condition Requiring Treatment

Give as much detail as possible regarding the TMD/TMJ and/or sleep conditions you have.

Additional space for further details.

What are your treatment goals related to the above conditions?

History

When did you first experience the above condition?

Was there a specific event that caused it?

If so, please describe the event(s).

What, if anything, makes it better?

What, if anything, that makes it worse?

Describe anything you have tried to make it better (devices, medicines, techniques, etc.).

Have you seen any other professionals regarding TMJ or Sleep?

Pain

Is there associated pain? If not, please skip the next few questions.

If there is pain, rate it from 1-10, with 10 being the worst pain you can imagine.

Describe how often/time of day you experience pain.

If pain is present, please describe it (sharp, dull, electrical, throbbing, etc.)

If pain is present, please describe the location.

If pain is present, does it radiate or seem to move to other areas?

If so, please give details of the visits.

Trauma History

Have you ever been in an automobile accident (even as a child)?

Have you ever had a sports injury involving the head or neck (even as a child)?

Have you had any personal injuries involving the head or neck (even has a child)?

Have you ever had a head or neck injury at the workplace?

Have you ever had head/neck surgery or a disease that impacted the head/neck?

If any of the above questions related to trauma were answered yes, please describe the injury.

TMJ/TMD Related Questions

Does your jaw pop on opening? Which side? Both?

Does your jaw click on opening? Which side? Both?

Pain in jaw joint? Which side? Both?

Clench/grind or broken teeth? Which side? Both?

Sleep Habits

How many hours of sleep per night do you get?

Describe how you normally sleep (back/side/stomach/etc.).

Do you snore on a regular basis?

Feel fatigued on a regular basis?

What is your neck size, in inches (leave blank if you don't know)?

Does anyone in your family have sleep apnea?

Stop breathing when sleeping/waking?

Catch yourself gasping when sleeping/waking?

On average, how many times do you wake up during the night?

If you have a partner, do you often disrupt their sleep?

Has weight loss ever helped your quality of sleep?

Sleep Study/CPAP Related

Have you ever had a sleep study?

If so, when was it?

Have you ever been prescribed a CPAP?

Have you ever tried a CPAP?

Do you currently use a CPAP?

If so, how many nights per week do you use it?

When you wear it, what percentage of the night do you keep it on?

Describe any complaints about a CPAP if you have tried it.

Have you ever worn a dental device for sleep apnea?

If so, was it made by a dentist or was it "over the counter?"

Have you ever had surgery for sleep apnea?

What severity of sleep apnea did study show?

Medical Questionnaire**Emergency Contact**

Emergency contact name

Emergency contact phone

Emergency contact relationship to patient

Medical Contacts

Primary Care Doctor Name/Phone #

ENT Doctor Name/Phone #

Sleep Doctor Name/Phone #

Dentist Name/Phone #

Other Doctor Name/Phone # _____

Other Doctor/Phone # _____

Medical Questions

Please list what you are allergic to. _____

Additional space for allergies. _____

Please list medications you are prescribed and/or take? _____

Additional space for medication list _____

Additional space for medication list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date

Dentist Signature

Date