New Patient Packet

PATIENT DEMOGRAPHICS

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

SSN: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Ethnicity: _____ Race: _____

Occupation: _____

2. Please upload the front and back of your government issued photo ID.

PARENT/GUARANTOR/RESPONSIBLE PARTY

3. Who is responsible for your account and payment? (if different from above)

Is this information different than above?
○ Yes ○ No

4. First Name: _____ Last Name: _____ SSN: _____

Birthdate: _____ Phone: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Email: _____

INSURANCE INFORMATION

5. Do you have medical and/or dental insurance?
   ○ Yes ○ No ○ Cash Only - I do not want to provide insurance information

6. **Primary Insurance (Please fill out the information below OR complete section 4 below to upload a picture of the front and back of your insurance card)**

   Policy Holder: _____ Policyholder's Birthdate: _____

   Insurance company: _____ ID#: _____ Group #: _____

   Insurance Phone: _____

7. **Upload the front and back of your PRIMARY insurance card**

   Any additional information that we need to be aware of...

   _____

8. Do you have a secondary insurance?
   ○ Yes ○ No

9. **Secondary Insurance (Please fill out the information below OR complete section 4 below to upload a picture of the front and back of your insurance card)**

   Policy Holder: _____ Policyholder's Birthdate: _____

   Insurance company: _____ ID#: _____ Group #: _____

   Insurance Phone: _____

10. **Upload the front and back of your SECONDARY insurance card**

    Any additional information that we need to be aware of...

    _____

REFERRAL INFORMATION

11. Were you referred to our office?
    ○ Yes ○ No

12. **How did you learn about our practice or whom may we thank for referring you?**

Referral Name/Source:

Referral Type:

☐ Doctor ☐ Dentist ☐ Specialist ☐ Patient ☐ Other

If Other, please specify:

13. If you weren't referred, how did you hear about our office?

DENTAL PROVIDER INFORMATION

14. Do you have a Dental Provider?

○ Yes ○ No

15. Dental Provider Information (Please fill out as much information as possible)

Dental Provider Office: Date of Last Visit:

Dentist Name: Office Phone:

Street Address: Apt./Unit #: City: State: Zip Code:

PRIMARY CARE PHYSICIAN INFORMATION

16. Do you have a Primary Care Provider?

○ Yes ○ No

17. Primary Care Provider Information (Please fill out as much information as possible)

Primary Care Physician Office: Date of Last Visit:

PCP Name: Office Phone:

Street Address: Apt./Unit #: City: State: Zip Code:

EMERGENCY CONTACT

18. Please list someone we are able to contact in case of an emergency.

Name:	Phone:	Relationship:

I voluntarily give my permission to the healthcare providers and professionals of Columbia Center for Sleep Apnea & TMJ to provide medical care and/or services as they deem necessary. I understand that by signing this form I am authorizing Columbia Center for Sleep Apnea & TMJ to treat me for the entirety of the time I seek services from the professionals employed by Columbia Center for Sleep Apnea & TMJ. By signing below, I also have read and agree to Columbia Center for Sleep Apnea & TMJ's Financial Policy and HIPAA Policy. If you would like a copy of any of these policies, please ask a member of the front desk to provide a copy for your records.

Signature

Date

Current Symptoms

19. What is the reason for your visit? - Select only those that apply

- ☐ Pain
- ☐ Sleep
- ☐ Frenectomy - Laser
- ☐ Solea Sleep - Laser/Snoring
- ☐ TMJ
- ☐ Imaging Only

20. In a few words, what results are you hoping from treatment?

_____

_____

_____

_____

21. Please select your chief complaint and/or symptoms that you experience the most:

- ☐ Back Pain
- ☐ Difficulty Closing Mouth
- ☐ Dizziness
- ☐ Dyskinesia
- ☐ Ear Congestion
- ☐ Ear Pain
- ☐ Ear Stuffiness
- ☐ Eye Pain
- ☐ Facial Pain
- ☐ Headach (inside head)
- ☐ Headache (outside head)
- ☐ Jaw Joint Locking
- ☐ Jaw Joint Noises
- ☐ Jaw Pain
- ☐ Limited Ability to Open
- ☐ Muscle Twitching
- ☐ Neck Pain
- ☐ Nerve Pain
- ☐ Numbess
- ☐ Pain When Chewing
- ☐ Shoulder Pain
- ☐ Sinus Congestion
- ☐ Throat Pain
- ☐ Tinnitus (Ringing in Ears)
- ☐ Vision Problems
- ☐ Acid Indigestion
- ☐ Affecting Sleep Partner
- ☐ Difficulty Falling Asleep
- ☐ Dry Mouth Upon Waking
- ☐ Fatigue
- ☐ Feel Unrefreshed in Morning
- ☐ Frequent Heavy Snoring
- ☐ Frequent Tossing & Turning
- ☐ Kicking/Jerking Legs Repeatedly
- ☐ Morning Headaches
- ☐ Morning Hoarseness in Voice
- ☐ Night Sweats
- ☐ Nighttime Choking Spells
- ☐ Nighttime Urination
- ☐ Repeated Awakening
- ☐ Shortness of Breath
- ☐ Sore Jaw Upon Waking
- ☐ Swelling in Ankles/Feet
- ☐ Teeth Crowding
- ☐ Teeth Grinding
- ☐ Told I Stop Breathing During Sleep
- ☐ Unable to Tolerate CPAP
- ☐ Vivid Dreams

Please list any symptoms not listed above.

_____

22. Rate your pain with 0 = no pain to 10 = worst possible pain you have ever experienced.

0	Currently	Best	Worst
Head Pain			
Neck Pain			
Facial Pain			

23. Please check any dental symptoms that you are currently experiencing:

- ☐ Changes in Bite
- ☐ Teeth Crowding
- ☐ Teeth Spacing
- ☐ Dental Changes
- ☐ Teeth Sensitivity
- ☐ None

24. Additional Sleep Questions

In which position do you sleep?
☐ Back ☐ Side ☐ Stomach
☐ Varies

Where do you sleep?
☐ Bed ☐ Chair ☐ Couch ☐ Other

Do you have a bed partner?
☐ Yes ☐ No

Is it easy for you to fall asleep?
☐ Yes ☐ No

How many times do you wake during the night?
☐ 0 ☐ 1 ☐ 2 ☐ 3+

Do you feel rested upon waking?
☐ Yes ☐ No

Has anyone ever told you that you stop breathing during sleep?
☐ Yes ☐ No

Have you ever had a sleep study?
☐ Yes ☐ No

If you have had a sleep study, please list the date and location of your study.

Medications

25. List medications you are currently taking and the reason why you are taking them. Include prescription, over-the-counter, vitamins, herbs, etc.

	Medication	Dose	Reason for Taking
1			
2			
3			
4			

Allergies

26. Please check any and all medications or substances that have caused an allergic reaction and list their reaction:

- ☐ Anesthetics _____
- ☐ Antibiotics _____
- ☐ Aspirin _____
- ☐ Barbiturates _____
- ☐ Other _____
- ☐ Codeine _____
- ☐ Iodine _____
- ☐ Latex _____
- ☐ Metals _____
- ☐ Penicillin _____
- ☐ Plastic _____
- ☐ Sedatives _____
- ☐ Sulfa _____

Medical History

27. Have you had prior orthodontic treatment?
☐ Yes ☐ No

Have you had sustained injury to:
☐ Head ☐ Face ☐ Neck ☐ Teeth

28. Please indicate if you have had any of the following:

- ☐ General Anesthesia
- ☐ Adenoids Removed
- ☐ Tonsils Removed
- ☐ Jaw Joint Surgery
- ☐ Orthognathic Surgery
- ☐ Oral Surgery
- ☐ Removal of Wisdom Teeth
- ☐ Nasal Surgery
- ☐ Other Major Surgery

If other, please list here

_____

Social History

29. Do you have trouble breathing through your nose?
○ Yes ○ No

Do you smoke tobacco?
○ Yes ○ No

Are you currently pregnant?
○ Yes ○ No ○ N/A

Do you consume alcohol?
☐ Yes ☐ No ☐ Habitually
☐ Socially

Do you drink 4 or more cups of coffee per day?
○ Yes ○ No

Do you take any sedatives/medications to help yourself fall asleep at night?
○ Yes ○ No

30. (Optional) Have you ever experienced:

- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Verbal Abuse
- ☐ None
- ☐ Emotional Abuse

31. Do you have or have you experienced any of the following?

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding Easily
- ☐ Bruising Easily
- ☐ Cancer
- ☐ Cold Hands and Feet
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing at Night
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Ehlers-Danlos Syndrome (EDS)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Fluid Retention
- ☐ Frequent Awakening at Night
- ☐ Frequent Colds/Flus
- ☐ Frequent Cough
- ☐ Frequent Ear Infections
- ☐ Frequent Sore Throat
- ☐ Gastroesophageal Reflux (GERD)
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Hearing Impairment
- ☐ Heart Disorder/Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Palpitations
- ☐ Heart Valve Replacement
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ History of Substance Abuse
- ☐ Huntington's Disease
- ☐ Hypoglycemia
- ☐ Insomnia
- ☐ Intestinal Disorder
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Memory Loss
- ☐ Meniere's Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Muscle Aches
- ☐ Muscular Dystrophy
- ☐ Muscle Fatigue
- ☐ Muscle Spasms
- ☐ Muscle Tremors
- ☐ Multiple Sclerosis
- ☐ Nervous System Disorder
- ☐ Neuralgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cyst
- ☐ Parkinson's Disease
- ☐ Poor Circulation
- ☐ Postural Orthostatic Tachycardia Syndrome (POTS)
- ☐ Psychiatric Care
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Rheumatoid Arthritis
- ☐ Rheumatoid Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Significant Daytime Drowsiness
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Slow Healing Sores
- ☐ Sleep Apnea
- ☐ Speech Difficulties
- ☐ Stroke
- ☐ Swollen, Stiff, or Painful Joints
- ☐ Thyroid Problem
- ☐ Tired Muscles
- ☐ Tuberculosis
- ☐ Urinary Tract Disorder

32. Does your family have a history of similar conditions, symptoms, or diseases?

- ☐ Yes
- ☐ No

_____ _____

Sleep Related Questions

33. Have you been prescribed a CPAP?

○ Yes ○ No

34. Do you use it as prescribed?

○ Yes ○ No

35. Have you had a previous oral appliance, mouth guard, splint, or retainer?

○ Yes ○ No

36. Do you use it as prescribed?

○ Yes ○ No

37. How many hours of sleep, on average, do you get per night?

_____

38. How many hours of sleep, on average, during the day?

_____

39. Do you ever cough, gasp, or snort upon waking?

○ Yes ○ No

Currently Experiencing

40. Are you currently experiencing head pain?

○ Yes ○ No

41. Location of your Head Pain

	Left	Right	Bilateral
Temple Area (Temporal)			
Back of Head (Occipital)			
Forehead (Frontal)			
Top of Head (Parietal)			
General Head Pain			

42. Time Frame of your Head Pain

	Recent	Chronic (over 6 months)
Temple Area (Temporal)		
Back of Head (Occipital)		
Forehead (Frontal)		
Top of Head (Parietal)		
General Head Pain		

43. Severity of your Head Pain

	Mild	Moderate	Severe
Temple Area (Temporal)			
Back of Head (Occipital)			
Forehead (Frontal)			
Top of Head (Parietal)			
General Head Pain			

44. Duration of your Head Pain

	Minutes	Hours	Days
Temple Area (Temporal)			
Back of Head (Occipital)			
Forehead (Frontal)			
Top of Head (Parietal)			
General Head Pain			

45. Frequency of your Head Pain

	Occasional	Frequent	Constant
Temple Area (Temporal)			
Back of Head (Occipital)			
Forehead (Frontal)			
Top of Head (Parietal)			
General Head Pain			

46. Are you currently experiencing jaw conditions?

○ Yes ○ No

47. If yes, please indicate all that apply:

	Left	Right	Bilateral
Jaw pain with opening			
Jaw pain with chewing			
Jaw pain at rest			
Jaw sounds with opening			
Jaw sounds when chewing			
Jaw sounds at rest			

48. Please indicate if you have had any of the following:

- ☐ Jaw Locks Closed
- ☐ Jaw Locks Open
- ☐ Daytime Teeth Clenching/Grinding
- ☐ Nighttime Clenching/Grinding
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Pain/Pressure behind eyes
- ☐ Extreme Sensitivity to light
- ☐ Wear Glasses or Contact Lenses

If other, please list here

_____

49. Are you currently experiencing any ear related conditions?

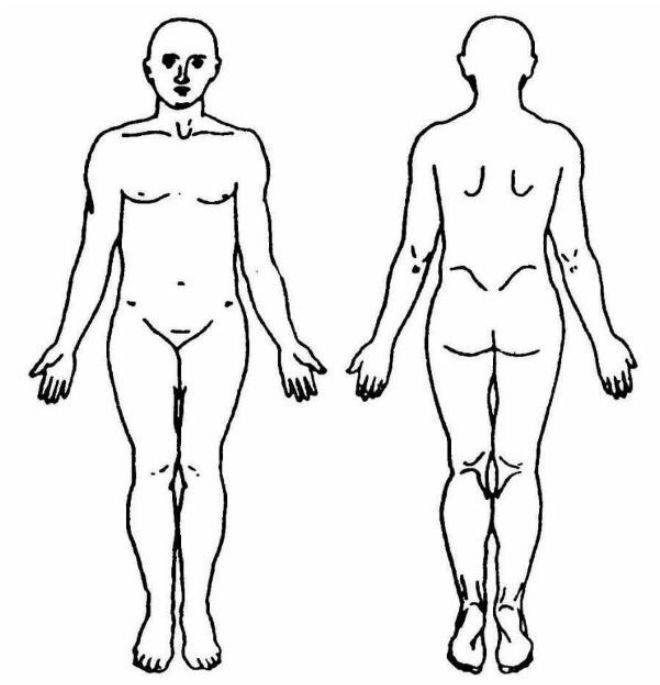
- ○ Yes
- ○ No

50. If yes, please indicate all that apply:

	Left	Right	Bilateral
Ear Congestion			
Ear Pain			
Hearing Loss			
Itchiness or Stuffiness in Ears			
Pain Behind the Ear			
Pain in Front of the Ear			
Recurrent Ear Infections			
Ringing in the Ear			

51. (Optional) Please indicate your areas of pain by labeling the body diagram according to the legend listed.

0 - 1-Mild Pain 1 - 2-Moderate Pain 2 - 3-Severe Pain



Explanation of areas of pain (optional)

52. Please indicate if you have had any of the following:

- ☐ Chronic Sore Throat
- ☐ Difficulty Swallowing
- ☐ Swollen Gland
- ☐ Thyroid Enlargement
- ☐ Tightness in Throat
- ☐ Constant Feeling of Foreign Object in Throat
- ☐ Lower Back Pain
- ☐ Upper Back Pain
- ☐ Neck Pain
- ☐ Numbness in hands/fingers
- ☐ Swelling in the neck
- ☐ Shoulder Pain
- ☐ Shoulder Stiffness
- ☐ Tingling in hands or fingers
- ☐ Frequent Biting of the Cheek
- ☐ Burning Tongue Sensation
- ☐ Middle Back Pain
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Chronic Sinusitis
- ☐ Broken Teeth
- ☐ Dry Mouth
- ☐ Limited Movement of Neck

If other, please list here

Symptom History

53. On what date, or approximate date, did your condition/symptoms first occur?

54. Can you relate your pain/condition to a motor vehicle accident or traumatic injury?

○ Yes ○ No

55. If yes, please explain:

_____

56. Does any family member have a sleep breathing disorder or Obstructive Sleep Apnea?

○ Yes ○ No

57. If yes, who:

_____

58. Does any family member have the same or a similar problem?

○ Yes ○ No

59. If yes, please explain:

_____

Additional History

60. Is there anything else you would like us to know?

_____

_____

_____

_____

You will sign our Financial Policy and Privacy-HIPAA Agreement in person when you arrive for your visit. As a reminder, please bring your government issued Photo ID and any insurance cards with you to your appointment. Thank you.

I agree, the above information is accurate and complete to the best of my knowledge.

_____ _____

Signature Date