Leslie B. Anthony, D. M. D.
Dentistry Perfected

TODAY'S DATE:_____

DENTAL SLEEP MEDICINE PATIENT INFORMATION	
Last Name:	First Name: Nickname: MI:
Street Address:	Patient Gender:
City: State: Zip:	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated
Mailing Address (if different from above):	If Married, Spouse's Name:
City: State: Zip:	Patient Birth Date (Month/Day/Year):
Home Phone:	Patient Social Security Number:
Cell Phone:	Patient Height:
Work Phone:	Patient Weight:
Employer/Position:	
Responsible Party Contact Name:	Email Address:
Relationship:	**Best contact** ◯ Home PH ◯ Cell PH ◯ Text ◯ Email
Responsible Party Contact Phone:	◯ Work PH
MEDICAL INSURANCE INFORMATION	
Primary Insured Name:	**Secondary** Insured Name:
Home Address (if not listed above):	Home Address (if not listed above):
Insurance Company: Claim Address: Insur co PHONE: FAX:	Insurance Company: Claim Address: Insur co PHONE: FAX:
Subscriber ID or SSN:	Subscriber ID or SSN:
Group Number:	Group Number:
Primary Insured Date of Birth (M/D/Y):	Secondary Insured Date of Birth (M/D/Y):
*** provide insurance cards for scan into our patient system	
CONTACT INFORMATION	
Primary Care Doctor:	Phone:
Sleep Doctor:	Phone:
ENT Doctor:	Phone:
Dentist: Last Appt:	Phone:
EMERGENCY CONTACT: _____ PHONE:_____ RELATIONSHIP:_____	Who Referred you to our office: _____ for Sleep Therapy

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PATIENT MEDICAL HISTORY

Please circle applicable answer. Your answers are for our records only and will be considered CONFIDENTIAL

Approximate date of your last dental exam:_____

1. Are you in good health? Yes No
   Has there been any change in your health in the past year? Yes No
2. Name of your primary care physician:_____Approximate date of your last physical exam:_____
3. Is a physician currently treating you? If so, why? _____ Yes No
4. Have you been hospitalized or had a serious illness within the last five (5) years? Yes No
   Description:_____
5. Have you experienced an unusual reaction to local anesthetic (e.g. novacaine)? Yes No
6. Are you allergic to latex? Yes No
7. Have you ever had any of the following? (Please check if applicable)

☐ Adenoids removed	☐ Dizziness	☐ Hepatitis A (Infectious)	☐ Osteoarthritis
☐ AIDS	☐ Drug Addiction	☐ Hepatitis B or C	☐ Osteoporosis
☐ Angina/Chest Pain	☐ Eating Disorder	☐ High blood pressure	☐ Pain in jaw joints (TMJ)
☐ Arteriosclerosis	☐ Emphysema	☐ HIV Positive	☐ Psychiatric Diagnosis_____
☐ Asthma / Breathing Problems	☐ Fibromyalgia	☐ Hypoglycemia	☐ Prior orthodontic treatment
☐ Autoimmune disorders	☐ Frequent Cough	☐ Injury to teeth	☐ Radiation
☐ Blood Disease	☐ Frequent sore throat	☐ Jaw Surgery	☐ Recent weight loss
☐ Cancer_____	☐ Gastric Reflux	☐ Kidney Problems	☐ Renal Dialysis
☐ Chemotherapy	☐ Glaucoma	☐ Leukemia	☐ Rheumatic Fever
☐ Chronic sinus problems	☐ Hay Fever	☐ Liver Disease	☐ Rheumatoid arthritis
☐ Chronic fatigue	☐ Heart murmur	☐ Learning Disability	☐ Stroke
☐ Cold Sores / Fever Blisters	☐ Heart pounding or beating	☐ Low blood pressure	☐ Thyroid disease
☐ Congenital Heart Disorder	irregularly during the night	☐ Lung Disease	☐ Tuberculosis
☐ Convulsions / Seizures	☐ Heart pacemaker	☐ Memory Loss	☐ Tumors or Growths
☐ Depression	☐ Heart palpitations	☐ Migraines	☐ Ulcers
☐ Diabetes	☐ Heart valve replacement	☐ Morning dry mouth	☐ Venereal Disease / HPV
☐ Difficulty concentrating	☐ Heartburn	☐ Nighttime sweating	☐ Wisdom teeth extraction

Have you ever had any serious disease or medical condition not mentioned above? Yes No Please Describe on next line:

_____

Do you have an artificial heart valve, hip prosthesis or other implant? Yes No

If yes, Name of your treating physician: _____ Date of surgery:_____

Cardiovascular:

Do you have chest pain on mild exertion? Yes No
Are you short of breath after mild exertion? Yes No
Do your ankles swell? Yes No
Do you get short of breath when you lie down? Yes No
Do you require extra pillows when you sleep? Yes No

Does your mouth frequently become dry? Yes No
Is there history of diabetes in your family? Yes No
Do you have to urinate frequently? Yes No

Does it make you anxious/nervous to visit the dentist? Yes No
Have you had any problems associated with previous dental treatment? Yes No
If yes, please explain_____
Do you think that your teeth are affecting your general health in any way? Yes No

If female, please check if you are ☐ pregnant ☐ nursing ☐ taking birth control pills

ASA

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Sleep Screening Questionnaire

Please answer the questions below to help us assess for possible sleep apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep apnea can increase your risk for many health conditions.

Name _____ Date _____

DOB _____ Height _____ Weight _____

	Yes	No
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	○	○
Are you currently being treated for OSA?	○	○
Are you aware of a family history of OSA?	○	○
Are you aware of clenching or grinding your teeth at night?	○	○
Are you currently using a CPAP? If yes, how often?_____	○	○

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	Chance of Dozing
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 in a lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____

STOP - BANG

			Yes	No
1.	**S**nore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?	○	●
2.	**T**ired	Do you often feel tired, fatigued or sleepy during daytime?	○	●
3.	**O**bstruction	Has anyone observed you stop breathing during your sleep?	○	●
4.	**P**ressure	Do you have or are you being treated for high blood pressure?	○	●
5.	**B**MI	Do you weigh more for your height than is shown in the table below?	○	●
6.	**A**ge	Are you 50 years old or older?	○	●
7.	**N**eck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	○	●
8.	**G**ender	Are you a male?	●	●

Height	Weight (lb)		Height	Weight (lb)		Height	Weight (lb)		Height	Weight (lb)
4’10”	167		5’3”	197		5’8”	230		6’1”	265
4’11”	173		5’4”	204		5’9”	237		6’2”	272
5’	179		5’5”	210		5’10”	243		6’3”	279
5’1”	185		5’6”	216		5’11”	250		6’4”	287
5’2”	191		5’7”	223		6’	258		6’5”	295
Weights shown in the tables above correspond to BMI of 35 for a given height.										

Patient Signature:_____

Form: STOP032018

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Dental Sleep Medicine Patient Questionnaire

Name _____ Date _____

Birthdate _____Height _____ Weight _____

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

_____

Thornton Snoring Scale

Answer 0-3 to the following situation

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

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 _____ TOTAL = _____

Other Complaints – Check all that apply

- ☐ Frequent Snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Nighttime heartburn / GERD
- ☐ Morning headaches
- ☐ Clenching or grinding teeth at night
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Irritability or mood swings
- ☐ Snoring which effects the sleep of others
- ☐ Others have observed me stop breathing while sleeping
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Nasal problems, difficulty breathing through nose
- ☐ TMJ or jaw pain
- ☐ Sounds in jaw joint (clicking, popping, grinding)
- ☐ Memory problems
- ☐ Other:_____

Subjective Signs & Symptoms – Rate on Scale of 1 - 10 1=Low 10=Excellent

Rate your overall energy level

Rate your sleep quality

Have you been told you snore? ☐YES ☐NO ☐SOMETIMES

Rate the sound of your snoring (1=quiet 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 bed partner notice you stop breathing?
☐SEVERAL TIMES/NIGHT ☐ONCE/NIGHT ☐SEVERAL TIMES/WEEK ☐ OCCASIONALLY ☐SELDOM☐ NEVER

Sleep Screening – Diagnosis and Treatment

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 do you wear it?_____
How many hours/night?_____

If you use or have used CPAP, what are your chief complaints about CPAP? – Check all that apply

- ❑ Mask leaks
- ❑ Inability to get mask to fit properly
- ❑ Discomfort from the straps or headgear
- ❒ Decreased sleep quality or interrupted sleep
- ❑ Noise from device disrupts sleep and/or Partners sleep
- ❑ Restricted movement during sleep
- ❒ CPAP seems ineffective
- ❑ Other:_____
- ❒ Device causes teeth or jaw problems
- ❒ Latex Allergy
- ❑ Device causes claustrophobia or panic attacks
- ❑ Unconscious need to remove CPAP at night
- ❑ GI / stomach / intestinal problems
- ❒ Irritated nasal passages
- ❑ Nasal problems
- ❑ CPAP caused dry nose or dry mouth
- ❑ Eye irritation due to air leaks

Are you currently wearing a dental device specifically designed to treat a sleep issue? ○YES ○NO
Have you previously tried a dental device for treatment of sleep issue? ○YES ○NO
If YES, was it purchased over the counter? ○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
List all 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 sleep disordered breathing and your sleep quality:

Brief Medical History

ALLERGIES – Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc.):

MEDICATIONS – Please list 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, stroke, hip replacement, diabetes, etc):

Dental History

Pre-MEDICATION – Have you been told you should take pre-medication before dental procedures? ○Y ○N
If YES, what medication and why do you require it?_____

How would you describe your dental health? ☐EXCELLENT☐GOOD☐FAIR☐POOR

Have you 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? ○YES○NO If YES, date completed:_____
Does your jaw joint click or pop? ○YES○NO
Do you have pain in the jaw joint? ○YES○NO
Have you had jaw joint (TMJ) surgery? ○YES○NO
Have you ever had gum problems? ○YES○NO If YES, have you had gum surgery? ○YES○NO
Do you have morning 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/Social History

Have genetic members of your family had:
Heart Disease? ○YES○NO High Blood Pressure? ○YES○NO Diabetes? ○YES○NO
Diagnosed or treated for a sleep disorder? ○YES○NO

How often do you consume alcohol within 2-3 hours of bedtime? ○DAILY ○OCCASIONALLY ○NEVER
How often do you take sedatives within 2-3 hours of bedtime? ○DAILY ○OCCASIONALLY ○NEVER
How often do you consume caffeine within 2-3 hours of bedtime? ○DAILY ○OCCASIONALLY ○NEVER

Do you Smoke? ○YES○NO If YES, number of packs/day_____
Do you use chewing tobacco? ○YES○NO

PATIENT SIGNATURE

I certify that the information I have completed on this form is true, accurate and complete to the best of my knowledge. Patient or Guardian Signature:_____ Date:_____

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SLEEP MEDICINE - FINANCIAL POLICIES / INSURANCE INFORMATION

Your dentist, physician or other health care provider has referred you to our office because of our unique expertise in treating sleep disorders. Our relationship with you as well as our ability to treat you is our highest concern. We are providing you with this information to help avoid misunderstandings regarding payment or insurance. Our aim is to never provide a service for you without first explaining the fees for that service.

Dr. Anthony is in a unique position with D.M.D. (dental) credentials to provide services customarily covered under your medical insurance benefits. Claims for evaluation and treatment with oral appliance therapy for obstructive sleep apnea are routinely filed under a medical insurance policy, not a dental plan.

Many medical insurance policies will provide reimbursement for a portion of your sleep disordered breathing evaluation and treatment. As a courtesy to our patients we are happy to bill your insurance provider(s). After your deductible is met, insurance typically covers a portion of their **allowable amount** for billed services. As an out-of-network provider, we will not typically know the insurance allowable amount until the insurance company approves payment.

If your policy provides benefits for obstructive sleep apnea and does not exclude oral appliances, your carrier may provide reimbursement of a percentage of the treatment fees. We suggest that you review your medical insurance policy or "Benefits Booklet" or call your insurance provider so that you may be aware of the specific benefits and limitations of your medical contract.

1. Payment is expected in full at the time the oral appliance is delivered to the patient, unless a financial payment or insurance billing procedure is agreed upon in advance of treatment. We accept all major credit cards, cash, personal checks and Care Credit.

2. For patients with medical insurance, the charges submitted to the insurance carrier will become due and payable 90 days from the date of filing if no response or payment is received. If the insurance company denies coverage, payment is due to our office immediately. If secondary insurance is carried, we will file the secondary claim once payment is received from the primary insurance. Explanation of Benefits (EOB) copies are required to submit the secondary claim. If a payment of insurance benefits is made to you directly and a secondary insurance is involved, you will need to supply our office with a copy of the EOB so that the secondary claim can be submitted for you.

3. Your medical insurance benefits are a contract between you, your employer and the insurance company. Any insurance information given to you by this office is *strictly an estimate* of benefits and *not a guarantee of payment*. Insurance benefit payments are determined solely by your insurance company and are subject to review of the claim, eligibility status and terms and conditions of your specific policy. This office is not responsible for monitoring patient's insurance policy limitations, waiting periods and plan maximums.

4. Insurance payments made directly to the patient for services provided by our office will be due and payable to us once received by the patient.

5. We are not a preferred provider or an in-Network provider for any medical insurance carrier.

6. We do not accept Medicaid.

Initial:_____

7. If your insurance policy has exclusion for treatment or if you are not covered by insurance, you will be required to make payment in full to our office at the time we deliver your oral appliance. The patient is responsible for all fees incurred in this office regardless of possible insurance coverage or delays. Coverage for procedures and the amount of reimbursement varies by insurance carrier. Some procedures may not be covered by your medical insurance.

8. If financial arrangements are agreed upon with our office, please outline them here:

9. Our office charges $25 for returned / insufficient funds checks.

10. Balances that are 60 days past due are subject to a 1.5% monthly service charge, which is an APR of 18%.

11. If your account is sent to collections, you will be responsible for any and all collection fees, court costs and/or attorney fees.

I ACKNOWLEDGE I HAVE READ AND AGREE TO ABIDE BY THE FINANCIAL POLICIES & THOSE DESCRIBED ABOVE.

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE: _____ DATE: _____

REPRESENTATIVE FOR DR. LESLIE B. ANTHONY DMD, PC: _____ DATE: _____