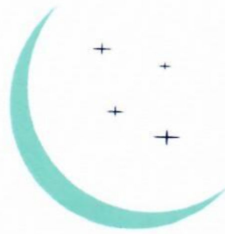

Allegheny
Dental
Sleep
Center

Welcome

Sleep Apnea is more common than people realize. Sleep apnea is a disorder characterized by pauses in breathing or limited breathing. People with sleep apnea have problems with excessive daytime sleepiness and its linked to many other medical conditions such as heart disease, liver disease and diabetes. An Oral Appliance can help you and your bed partner get a good night's sleep and it can improve your health and quality of life. Please complete the following info so that we can better help you.

About You

Name: ______________________

I prefer to be called: ______________________

Home Address: ______________________
____

Home Phone: ______________________

Work Phone: ______________________

Cell Phone: ______________________

Email: ______________________

SS#: ______________________

DOB ______/______/______ Age ______

Marital Status: ______________________

Employer Name: ______________________

Employer Address: ______________________
____

Occupation: ______________________

Spouse Information: ______________________

Spouse's Name: ______________________

Spouse's Employer: ______________________

Spouse's Name: ______________________

Spouse's Dob: ______/______/______

Medical Insurance

Subscriber Name: ______________________

Relation To Patient: ______________________

Subscriber Id Or SS#: ______________________

Subscriber DOB: ______/______/______

How did you hear about us? ______________________
____

Are you currently under a physician's care? ☐ Yes ☐ No

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

Have you ever had a serious head, concussion or neck injury? ☐ Yes ☐ No

Physicians Name:	Physicians Phone:
Pharmacy Name:	Pharmacy Phone:

Sleep Apnea Questionnaire:

Do you smoke or use tobacco? ☐ Yes ☐ No

Do you snore loudly? ☐ Yes ☐ No

Do you often feel tired, fatigued or sleepy during the day? ☐ Yes ☐ No

Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No

Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No

Are you currently on medication? ☐ Yes ☐ No

Please list all medications you are currently taking: ____________________

Please list any allergies: ____________________

Conditions

	Yes	No		Yes	No		Yes	No
AIDS/HIV' Positive	☐	☐	Drug Addiction	☐	☐	Mitral Valve Prolapse	☐	☐
Alzheimer's	☐	☐	Emphysema	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Epilepsy or Seizures	☐	☐	Radiation Treatments	☐	☐
Arthritis/Gout	☐	☐	Glaucoma	☐	☐	Rheumatic Fever	☐	☐
Artificial Heart	☐	☐	Hay fever	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Heart Attack Failure	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Blood Transfusion	☐	☐	Heart Pace Maker	☐	☐	Stroke	☐	☐
Breathing Problem	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Hemophilia	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Hepatitis A	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Hepatitis B or C	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Venereal Disease	☐	☐
Concussions	☐	☐	Hives or Rash	☐	☐	Yellow Jaundice	☐	☐
Heart disorder	☐	☐	Irregular Heartbeat	☐	☐			
Alcohol Abuse	☐	☐	Low Blood Pressure	☐	☐			

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform and necessary services that I may need during diagnosis and treatment with my informed consent, I understand that I am responsible for payment of services rendered.

Patient Signature: ____________________ Date: __________