Sleep Health Questionnaire

EZ SLEEP In-Home Testing

☐ M ☐ F

Name | Gender | DOB

Address, City, State, Zip | Weight | Height

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score		

Risk Level	Low	Moderate	High	Severe
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

☐ Hypertension ☐ Snoring ☐ Diabetes

☐ Depression ☐ Grind Teeth ☐ Acid Reflux

☐ Stroke/Heart Disease ☐ Unrefreshed Sleep

☐ Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

Do you use your CPAP less than 5 times a week? ☐ Yes ☐ No

Would you prefer an oral appliance? ☐ Yes ☐ No

Please Present Completed Form, ID & Medical Insurance Card to Front Desk to Allow for Copies

Fax: 888-999-1887 Email: orderentry@ezsleeptest.com Phone: 888-240-7735

STANLEY COHEN, D.D.S., P.A.

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____ Home Phone:_____

Marital status: _____ Spouse name (if applicable):_____ Spouses work phone:_____

Address:_____ City: _____ State: ____ Zip: _____

Employer:_____ Occupation: _____ Work Phone:_____

Business Address: _____ City: _____ State: ____Zip: _____

Social Security #: _____ Cell Phone #: _____ E-mail _____

Contact preference: phone / e-mail_____

How were you referred to this practice? _____

If you are completing these forms for another person, what is your relationship to that person? _____

Person to notify in case of an emergency: _____ Phone:_____

Relationship of this person to you: _____

FINANCIAL RESPONSIBILITY

Is the patient financially responsible for this account? _____ (If yes, skip to insurance section of form)

Financially Responsible Party: _____ Relationship to the patient: _____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone:_____ Employer: _____ Work Phone:_____

INSURANCE INFORMATION

Is the patient covered by dental insurance? _____ (If no, skip to medical history portion of form)

Policy Subscriber: _____ Insurance Company: _____

Subscriber's Address: _____ Insurance Address: _____

_____

Relationship to patient: _____ Insurance Group #: _____

Social Security #: _____ Subscriber's Birth Date: _____ Insurance ID #: _____

Subscriber's Employer: _____ Employer's Address: _____

If the patient also has secondary insurance coverage, please complete the following:

Policy Subscriber: _____ Insurance Company: _____

Subscriber's Address: _____ Insurance Address: _____

_____

Relationship to patient: _____ Insurance Group #: _____

Social Security #: _____ Subscriber's Birth Date: _____ Insurance ID #: _____

Subscriber's Employer: _____ Employer's Address: _____

STANLEY COHEN, D.D.S., P.A.

MEDICAL HISTORY

What is your impression of your present health (excellent, good, poor)? _____

Physician's name and phone number: _____ Year of last medical physical: _____

HAVE YOU EVER HAD OR DO YOU HAVE AT PRESENT? : (Please check to the right of each item)

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Heart Disease or Heart Condition				Blood Transfusion				Sexually Transmitted Disease (Syphilis, Gonorrhea)			
High or Low Blood Pressure				Sickle Cell Disease				AIDS or AIDS Related Complex			
Pacemaker				Other Blood Diseases				HIV Positive			
Angina Pectoris				Arthritis				Herpes			
Frequent Chest Pains				Asthma				Thyroid Disease			
Heart Attack				Sinus Trouble				Epilepsy or Seizure Disorder			
Shortness of Breath				Emphysema				Fainting or Dizzy Spells			
Swollen Ankles				Other Respiratory Diseases				Cold Sores			
Valve Disease				Tuberculosis				Jaundice			
Artificial Heart Valve				Diabetes				Hepatitis			
Congenital Heart Disease				Ulcers				Liver Disease			
Heart Murmur				Kidney Trouble				Sleep Apnea			
Rheumatic Fever				Implant Prosthesis				Drug/Alcohol Dependency			
Stroke				Frequent Headaches				Depression			
Bleeding Disorder				Joint Replacement				Radiation Therapy			
Bruise Easily				Cancer				Chemotherapy			
Prolonged/ Unusual Bleeding				Premedication for Dental Treatment				Neurological Problems			
Anemia				G.I. Tract Problems				Psychiatric Treatment			

Do you have any other medical problems not mentioned above? _____Please list_____

_____

Have you had major operations? _____ Please list_____

Are you allergic to any drugs/medications/materials (e.g., latex)? _____ Please list_____

Do you snore?_____ Have you ever been told you snore? _____

What (if any) medications are you currently taking? (Include Birth Control Pills and Over the Counter Medication)

_____

Do you smoke or use smokeless tobacco? _____ Are you wearing contact lenses? _____

Women

Are you pregnant? _____ If yes, what week? _____ Are you nursing?_____

STANLEY COHEN, D.D.S., P.A.

DENTAL HISTORY

When was your last dental appointment? _____

Are you satisfied with the appearance of your teeth? _____

If not, what would you like changed? _____

Do you have any sensitive teeth? _____ If yes, where? _____

Do you have any loose teeth? _____ If yes, where? _____

Have you noticed any swelling, lumps or sores in your mouth? _____ If yes, where? _____

Do you have difficulty chewing your food? _____ If yes, where? _____

Do you have areas which break floss or where food lodges? _____ If yes, where? _____

Have you had a toothache recently? _____ If yes, where? _____

Do your gums bleed when you brush/floss? _____

Have you had orthodontic treatment (Braces)? _____

Have you had periodontal (Gum) treatment? _____

Do you grind, clench or grit your teeth? _____

Are you aware of any clicking or popping in either TMJ (jaw joint)? _____

Do you experience any discomfort in either TMJ (jaw joint)? _____

What type of toothbrush are you now using (soft, medium, hard)? _____

Do you use dental floss? _____ If so, how often? _____

When did you last receive instruction on proper cleansing of your teeth? _____

Please list any dental concerns that you would like to bring to our immediate attention: _____

_____

Have you had any serious trouble associated with previous dental treatment? _____

What is the reason for today's visit? _____

What is your reaction to having dental treatment? Dread it _____ Worry about it _____ Don't mind it _____

I certify that the answers given are correct to the best of my knowledge. Furthermore, I understand that even though I may have some type of insurance coverage, I am financially responsible for services rendered. I hereby authorize release of any information regarding my insurance claims to my insurance company.

_____ _____

Signature (Parent or guardian, if patient is a minor) Date

I hereby authorize payment of my insurance benefits directly to the office of Stanley Cohen, D.D.S., P.A.

_____ _____

Signature (Parent or guardian, if patient is a minor) Date

Stanley Cohen, D.D.S., P.A.

18109 Prince Phillip Dr., Ste 250
Olney, MD 20832

Phone: (301)774-1020

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard.

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

x_____
*Date:*_____