Sleep Health Questionnaire

☐ M ☐ F / /

Patient Name | Gender | DOB

Address, City, State | Zip

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

FOR PATIENT USE

Patient Sleepiness Scale (Risk Factors): *Please check all that apply.*		**pt.**	*Additional comments below:*
1. I have been told I stop breathing while asleep	☐	8	
2. I have fallen asleep or nodded off while driving	☐	6	
3. I've woken up with shortness of breath / gasping or my heart racing	☐	6	
4. I feel excessively sleepy or fatigued during the day	☐	4	
5. I snore or have been told that I snore	☐	4	
6. I have had weight gain and found it difficult to lose	☐	4	
7. I have been diagnosed with high blood pressure	☐	4	
8. It takes me less than 10 minutes to fall asleep	☐	4	
9. I wake up more than 1 time per night	☐	4	
10. I wake up with headaches	☐	4	

Total points from above _____ .Check your Risk Level Score: ☐ **Low:** *0-7* ☐ **Moderate:** *8-11* ☐ **High:** *12-15* ☐ **Severe:** *16+*

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FOR PATIENT USE

Patient Health History (Signs & Symptoms): *Please check all that apply.*

- ☐ Snoring
- ☐ Depression/Anxiety
- ☐ Unrefreshed Upon Waking
- ☐ Witnessed Choking/Gasping/Apnea
- ☐ Irritability/Moodiness
- ☐ Wakes Up with Dry Mouth
- ☐ Sinus/Allergy Issues
- ☐ Grind Teeth
- ☐ Diabetes
- ☐ History of Stroke/Heart Disease
- ☐ Acid Reflux/GERD
- ☐ Hypertension
- ☐ Memory Loss
- ☐ Family History of OSA/Snoring
- ☐ Deviated Septum
- ☐ Currently Not Using Prescribed CPAP

I authorize this practice to release any medical information for the purpose of the coordination of care.

Patient Signature **Date**

Ask your dentist to complete.

- ☐ BMI > 30 (see reverse)
- ☐ Narrow upper arch
- ☐ Visual airway obstruction
- ☐ Large/scalloped tongue
- ☐ Neck size: Male ≥ 17" or Female ≥ 16"

' "

Height | lbs Weight

inches Neck Size | Blood Pressure

BPM Heart Rate | BMI

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Prescription / Statement of Medical Necessity

*Certain insurance payers require a minimum **Risk Level Score of High** and/or **at least two (2) Signs & Symptoms**; sometimes up to four (4).*

Home sleep study (*G47.33 to be used to rule out OSA, unless stated differently. If other, please specify*): _____

- ■ **Baseline 2-Night or (____-Night) home sleep study**
- ☐ **Assessment of oral appliance efficacy**

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

ET

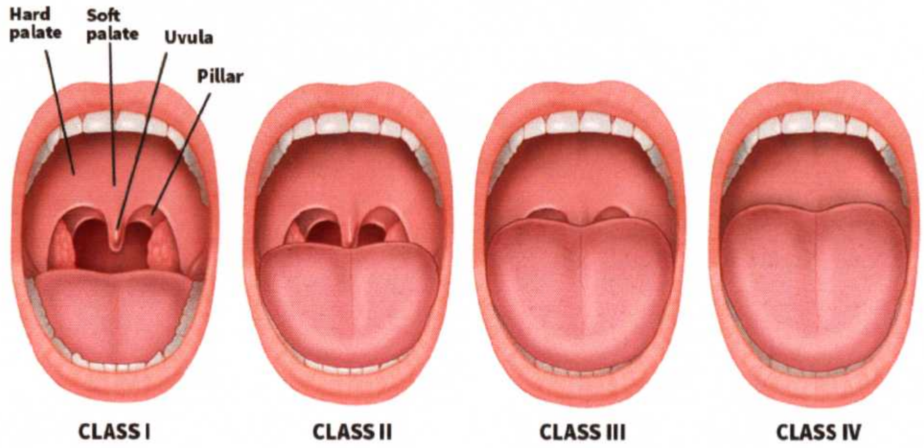
Dr. Signature State Lic#: 09415 **Date** Account Code

Stanley Cohen, D.D.S., P.A.
Dr. Stanley Cohen
18109 Prince Philip Drive, Suite 250,
Olney, MD 20832
NPI#: 1538107347
Office Contact: Dr. Cohen
Phone: (301) 774-1020
cohen2000@ymail.com
officecohen@yahoo.com

FOR OFFICE USE

Mallampati Score & BMI Chart

Visual Obstruction and Body Mass Index Reference Sheet



	Normal						Overweigh t					Obese					Extreme Obesity																			
BMI (kg/m2)	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)																	Weight (pounds)																			
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

EzSleep™ In-Home Testing

Fax: 888-999-1887 • OrderEntry@EzSleepTest.com • Phone: 888-240-7735

Fax or email completed frontside form with copies of ID & medical insurance cards

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:*_____

COMPLETE FAMILY DENTISTRY

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

Stanley Cohen, D.D.S., P.A.
18109 Prince Philip Dr.
Suite 250
Olney, MD 20832

Ph: 301-774-1020
FAX: 301-774-1062
E-MAIL: officecohen@yahoo.com

Release of Records

Date:_____

To the office of:_____ Address:_____

FAX:_____ _____

Please release any and all x-rays and /or records for _____to the office of:

Stanley Cohen, D.D.S., P.A.
18109 Prince Philip Dr., Suite 250
Olney, MD 20832

Thank you,

_____
Patient Signature