QUALITY Sleep SOLUTIONS

New Patient Paperwork

Responsible Party (If Someone Other Than The Patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ SSN: _____

DLN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

☐ Responsible Party is also Policy Holder For Patient ☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ SSN: _____

DLN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Seperated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Preferred Pharmacy: _____

Employer ID: _____ Emergency Contact Name: _____

Carrier ID: _____ Emergency Contact Phone: _____

Last Dental Visit Date: _____

Previous Dentist: _____

Referred By: _____

Primary Insurance Information

Name Of Insured: _____ Insurance Company: _____

Insurance ID: _____ Group ID: _____

Insured SSN: _____ Insured DOB: _____

Employer: _____

Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Information

Name Of Insured: _____ Insurance Company: _____

Insurance ID: _____ Group ID: _____

Insured SSN: _____ Insured DOB: _____

Employer: _____

Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Patient Name: _____ Patient Date Of Birth: _____ Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body, health problems that you may have, or medication that you may be taking, could affect your care.

Are you under a physician's care now?	☐ Yes	☐ No	If Yes: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If Yes: _____
Haye you ever had a serious head or neck injury?	☐ Yes	☐ No	If Yes: _____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If Yes: _____
Do you take a blood thinner? Please name the blood thinner.	☐ Yes	☐ No	If Yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing	☐ Yes	☐ No	If Yes: _____
Are you on a special diet?	☐ Yes	☐ No	If Yes: _____
Do you use tobacco?	☐ Yes	☐ No	If Yes: _____

Women: Are You Currently...

☐ Pregnant / Trying to become pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following:

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anestetics

Do you use controlled substances?	☐ Yes	☐ No	If Yes: _____
Do you use any other substances we should know about?	☐ Yes	☐ No	If Yes: _____

Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	RadiationTreatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	EasilyWinded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	ExcessiveThirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting Spells / Dizziness	☐	☐	Irregular Heartbeat	☐	☐	SinusTrouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach / Intestinal Disease	☐	☐
Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	HeartAttack / Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores / Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain In Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	HeartTrouble / Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Yellow Jaundice	☐	☐									

Have you ever had any illness not listed above: ☐ Yes ☐ No If Yes: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's} health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

QUALITY Sleep SOLUTIONS

S. T. O. P. B. A. N. G. QUESTIONNAIRE

Patient Name: _____ Patient Date Of Birth: _____ Date Created: _____

Height: _____ Inches Weight: _____ LBS Age: _____ Sex: ☐ Male ☐ Female

Collar Size of Shirt: ☐ S ☐ M ☐ L ☐ XL -OR- _____ inches

Snoring	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes	☐ No
Tired	Do you often feel tired, fatigued, or sleepy during daytime?	☐ Yes	☐ No
Observed	Has anyone observed you stop breathing during your sleep?	☐ Yes	☐ No
Blood Pressure	Do you have or are you being treated for high blood pressure?	☐ Yes	☐ No
BMI	Are you overweight?	☐ Yes	☐ No
Age	Age over 50 yr old?	☐ Yes	☐ No
Neck circumference	Neck circumference greater than 16""?	☐ Yes	☐ No
Gender Male?		☐ Yes	☐ No

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from: STOP Questionnaire A Tool to Screen Patients for Obstructive Sleep Apnea Frances Chung, F.R.C.P.C., * Balaji Yegneswaran, M.B.B.S., Pu Liao, M.D., I Sharon A. Chung, Ph.D., Santhira Vairavanathan, M.B.B.S., Sazzadul Islam, M.Sc.,_Ali Khajehdehi, M.D.,t Colin M. Shapiro, F. R.C.P.C.# Anesthesiology 2008; 108:812-21