Anne B. Filler DMD, MAGD
COSMETIC & GENERAL DENTISTRY

Sleep Intake Form

Personal Information

Name: _____ (First) _____ (Last) Today's Date: ____/____/_____

Address: _____ Phone (H): _____

City: _____ Phone (C): _____

Email: _____ Phone (W): _____

Date of Birth: ____/____/_____ Age: _____ Gender: ☐ F ☐ M

Employer: _____ Occupation: _____

How did you hear about us? Internet: Referral:_____ Other: _____

In case of emergency, who should be notified? _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Sleep Physician: _____ Phone: _____

Sleep Facility: _____ Phone: _____

Date of Baseline Sleep Study: ____/____/_____ CPAP Trial:

Patient Chief Complaint and Patient Expectations

Briefly describe your problem with your sleep as you see it.

What is the nature of assistance you expect or desire?

Notice of Privacy Practices Acknowledgement:

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: ____/____/_____

Sleep History

Have you ever had your sleep evaluated before? Sleep Study Date: ____/____/_____

What were you told your final assessment (diagnosis) was?

What treatment options were you offered?

What prompted today's evaluation?

Have you had any oral surgeries to treat your sleep symptom?

Do you work swing-shift or nighttime shifts?

Please check the appropriate box below:			Have you ever tried any of the following to help improve your sleep breathing?		
High Blood Pressure	☐ Yes	☐ No	CPAP	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No
History of Heart Attack or Stroke	☐ Yes	☐ No	Nose Cones or Strips	☐ Yes	☐ No
Mood Disorder	☐ Yes	☐ No	Side Sleeping	☐ Yes	☐ No
Impaired Thinking	☐ Yes	☐ No	Surgical Treatments	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No			

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

This refers to your usual way of life in recent times.

Sitting and reading	0
Watching television	0
Sitting inactive in a public place (i.e. a theater)	0
A passenger in a car for an hour without a break	0
Lying down to rest in the afternoon when possible	0
Sitting quietly after a lunch without alcohol	0
In a car while stopped for a few minutes in traffic	0
Overall quality of sleep- poor, average, good **TOTAL**	**0**

SCALE
0 - Would Never Fall Asleep
1 - Slight Chance of Dozing
2 - Moderate Chance of Dozing
3 - High Chance of Dozing

Patient Signature _____ Date: ____/____/_____

CPAP Intolerance Affidavit

Patient's Name: _____

Date: ____/____/_____

I have attempted to use CPAP (Continuous Positive Air Pressure) to manage my obstructive sleep apnea and find it intolerable to use on a regular basis for the following reason(s):

- ☐ Mask Leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise from the device disturbing sleep or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ Pressure on the upper lip cause tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night
- ☐ Other: _____

Because of my intolerance and or inability to use the CPAP, I wish to have my obstructive sleep apnea treated with a custom fabricated oral device used to
reduce upper airway collapsibility.

Patient Signature: _____ Date: ____/____/_____