Xceptional Sleep
JANETTE LARSEN, DMD

2044 Chatsworth Blvd.
San Diego, CA 92107
619-223-6767
XceptionalSleep.com

Welcome to Xceptional Sleep

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible.

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR. Today's Date:_____

FULL LEGAL NAME: _____ PREFERRED: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

Primary PHONE: _____ CELL PHONE: _____ TEXT OK? (circle) Yes / No

GENDER: _____ E-MAIL ADDRESS: _____

SSN: _____-_____-_____ DATE OF BIRTH: _____/_____/_____ AGE:_____

RESPONSIBLE PARTY: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

YOUR EMPLOYER: _____ ADDRESS: _____

REFERRED BY / SLEEP MD: _____ ADDRESS OR PHOHE: _____

FAMILY PHYSICIAN: _____ ADDRESS OR PHONE: _____

FAMILY DENTIST: _____ ADDRESS OR PHONE: _____

☐ Please check box if you are pregnant or think you might be, **and** let our office know.

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

POLICY HOLDER: _____ POLICY HOLDER: _____

POLICY HOLDER DOB: _____ POLICY HOLDER DOB: _____

WHAT ARE THE CHIEF SYMPTOMS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important or bothersome to you.

_____ Frequent heavy snoring
_____ Snoring that affects the sleep of others
_____ Sleep apnea
_____ CPAP intolerance
_____ Significant daytime drowsiness
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nighttime choking spells
_____ Swelling in ankles or feet
_____ Feeling un-refreshed in the morning

_____ Morning hoarseness
_____ Morning headaches
_____ Nocturnal teeth grinding
_____ Jaw pain
_____ Facial pain
_____ Jaw clicking

Other:
_____
_____

Office Use Only:

_____ °F
BP:_____
Pulse: _____
Height: _____
Weight: _____

Patient Name: _____ Height: _____ Weight: _____

Epworth Sleepiness Scale

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

0 = I would never doze **2** = I have a moderate chance of dozing

1 = I have a slight chance of dozing **3** = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

		Yes	**No**	**Not Sure**
	Have you been told (or noticed on your own) that you snore most nights?	□	□	□
	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep, sometimes followed by a GASP?	□	□	□
	Are you tired, fatigued or sleepy on most days?	□	□	□
	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	□	□	□
	Are you overweight?	□	□	□
	Have you ever been diagnosed with obstructive sleep apnea (OSA)?	□	□	□
	Are you currently being treated for OSA?	□	□	□
	Are you aware of family history of OSA?	□	□	□
	Are you aware of clenching or grinding your teeth at night?	□	□	□
	Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?	□	□	□
	Do you often feel tired, fatigued or sleepy during daytime?	□	□	□
	Has anyone observed you stop breathing during your sleep?	□	□	□
	Do you have or are you being treated for high blood pressure?	□	□	□
	Are you 50 years old or older?	□	□	□
	Does your neck measure more than 15 ¾ inches (40cm) around?	□	□	□
	Are you a male?	□	□	□
	Do you weigh more for your height than is shown in the table below?	□	□	□

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4’10”	167	5’3”	197	5’8”	230	6’1”	265
4’11”	173	5’4”	204	5’9”	237	6’2”	272
5’	179	5’5”	210	5’10”	243	6’3”	279
5’1”	185	5’6”	216	5’11”	250	6’4”	287
5’2”	191	5’7”	223	6’	258	6’5”	295
Weights shown in the tables above correspond to BMI of 35 for a given height.							

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:

_____

_____

_____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND REASON FOR TAKING THE MEDICATION:

_____

_____

_____

_____

_____

MEDICAL HISTORY

Y☐ N☐ Adenoids removed
Y☐ N☐ Tonsils removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Chronic sinus problems
Y☐ N☐ Chronic fatigue
Y☐ N☐ Congestive heart failure
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent sore throat
Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
Y☐ N☐ Hay fever
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pounding or beating Irregularly during the night
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to face
Y☐ N☐ Injury to mouth
Y☐ N☐ Injury to neck
Y☐ N☐ Injury to teeth
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nighttime sweating
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Shortness of breath
Y☐ N☐ Swollen, stiff, or painful joints
Y☐ N☐ TMJ disorder
Y☐ N☐ Thyroid problems
Y☐ N☐ Wisdom teeth extraction

Y☐ N☐ Other medical/dental history _____

_____

_____

FAMILY HISTORY

Do you have a loved one that has been diagnosed with obstructive sleep apnea and is not currently being treated? Y□ N□

Do you have a loved one you think might have undiagnosed sleep apnea? Y□ N□

Have any members of your family (blood kin) had:

Y□ N□ Heart disease
Y□ N□ High blood pressure
Y□ N□ Diabetes

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center? Y ☐ N ☐

Sleep Center Name _____Location_____ Date of Study _____

CPAP (Continuous Positive Airway Pressure device)

Have you used CPAP? Y□ N□ For how long: _____

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to: (mark all that apply)

_____Mask leaks
_____I was unable to get the mask to fit properly
_____Discomfort caused by the strap or headgear
_____Disturbed or interrupted sleep caused by the presence of the device
_____Noise from the device disturbing my and/or bed partner's sleep
_____CPAP restricted movements during sleep
_____CPAP does not seem to be effective
_____Pressure on the upper lip causing tooth related problems
_____A latex allergy
_____Claustrophobic associations
_____An unconscious need to remove the CPAP apparatus at night
_____Other: _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders (weight loss, smoking cessation, surgery, etc.)?

_____

_____

Has any doctor recommended that you have surgery for this condition? Y□ N□

SOCIAL HISTORY

How often do you consume alcohol within 2-3 hours of bedtime?

□ Never □ Once a week □ Several days a week □ Daily

How often do you take sedatives within 2-3 hours of bedtime?

□ Never □ Once a week □ Several days a week □ Daily

How often do you consume caffeine within 2-3 hours of bedtime?

□ Never □ Once a week □ Several days a week □ Daily

Do you smoke? Y □ N □ If YES, how many a day? _____

Do you use chewing tobacco? Y □ N □

Patient SIGNATURE_____ Date _____

Doctor Signature: _____ *Date* _____

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Appointment & Financial Policies

Appointment Policy

Missed appointments, or those cancelled with less than 48 business hours of the scheduled appointment time, may be charged a $60 missed-appointment fee

- We believe that we can provide optimal dental care only if we have enough time to thoroughly examine your condition and discuss any treatment options. The same is true for treatment that has been scheduled.
- Your appointment is reserved exclusively for you. If you miss or fail to attend your appointment or cancel at the last moment, we will be unable to care for another patient. If you arrive 10 or more minutes late for your appointment, we may need to reschedule your appointment to allow us to stay on time for our other scheduled patients. This is considered a "missed appointment".
- If you think that you may be late for your appointment, please call us as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule your appointment and assess a fee. We respect your time as well, and in the event that we have unforeseen issues and will be running late, we will attempt to notify you. This is why we ask for the "best" number/manner to reach you on short notice.
- We realize that there can be circumstances beyond (y)our control and we always take that into consideration.

Appointment Notification Protocol

- Our notification/reminder system will help you confirm upcoming appointments and provide efficient reminders. You may opt-out at any time.
- The information you provide us, such as email and cell phone numbers are a protected part of your health care record. We do not share nor release this information outside of this office. Your privacy is important to us.

Please check your preferred method for automated Appointment Reminders:

☐ Text Message ☐ Email Message ☐ Phone Message ☐ NONE

Financial Policy

I will pay my full payment or, if insured, my estimated co-insurance to Dr. Larsen at the time of my visit unless other arrangements are made in advance. If I have medical/dental insurance, any difference remaining between the estimated insurance coverage and actual payment made by my insurance will be invoiced (or reimbursed) to me upon completion of insurance processing, typically within 45 days from the date of service.

In the event a balance remains on account more than 45-days after insurance payment, the balance is subject to 1.0% interest monthly, limited to 12% per year. If account is not paid within 90-days of insurance payment, the undersigned will be responsible for legal fees, collection agency fees, interest charges, late fees and any other expenses incurred in collecting past-due account.

I authorize and request my Medical/Dental Benefit Plan (Insurance) to assign benefits to Dr. Larsen and pay the office directly for covered services. My insurance may pay less than the actual bill or estimated portion for services and neither Dr. Larsen nor the insurance carrier can or will guarantee insurance payment amounts in advance.

You may pay for services using cash, personal check, Visa/MC, Discover & American Express. Additionally, we offer CareCredit™ as an alternative for monthly payments if you qualify.

_____ _____ _____

Responsible Party Printed Name *Signature* *Date*