

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 PHONE: _____

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: _____

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

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

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 _____

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 \$50 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