

## 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:**

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

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**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<br>Irregularly during the night | <input type="checkbox"/> <input type="checkbox"/> Needing extra pillows to help<br>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<br>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<br>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 \_\_\_\_\_

## Nasal Obstruction Symptom Evaluation (NOSE) Score

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 Email \_\_\_\_\_

Please help us better understand the impact of nasal obstruction on your quality of life by completing the below. Over the past **4 weeks**, how much of a **problem** were the following symptoms for you?

| <b>Please mark the most correct response</b>                         | <i>Not a Problem</i><br><b>0</b> | <i>Mild Problem</i><br><b>1</b> | <i>Moderate Problem</i><br><b>2</b> | <i>Fairly Bad Problem</i><br><b>3</b> | <i>Severe Problem</i><br><b>4</b> |
|--|----------------------------------|---------------------------------|-------------------------------------|---------------------------------------|-----------------------------------|
| Nasal Congestion or Stuffiness                                       | <input type="radio"/>            | <input type="radio"/>           | <input type="radio"/>               | <input type="radio"/>                 | <input type="radio"/>             |
| Nasal Blockage or Obstruction  | <input type="radio"/>            | <input type="radio"/>           | <input type="radio"/>               | <input type="radio"/>                 | <input type="radio"/>             |
| Trouble Breathing Through My Nose                                    | <input type="radio"/>            | <input type="radio"/>           | <input type="radio"/>               | <input type="radio"/>                 | <input type="radio"/>             |
| Trouble Sleeping   | <input type="radio"/>            | <input type="radio"/>           | <input type="radio"/>               | <input type="radio"/>                 | <input type="radio"/>             |
| Unable to Get Enough Air Through My Nose During Exercise or Exertion | <input type="radio"/>            | <input type="radio"/>           | <input type="radio"/>               | <input type="radio"/>                 | <input type="radio"/>             |

**Does the Cottle Maneuver help you breathe better?**  
 Follow the steps pictured here.

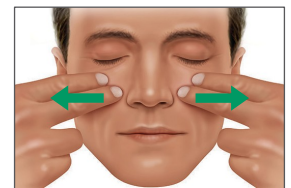
**YES**      **NO**

**Do you use nasal strips during activity or sleep?**

**YES**      **NO**



**Step 1:** Place two fingertips on your cheeks, on each side of your nose.



**Step 2:** Gently press and pull outward. Breathe through your nose.

### Office Administration

Sum the answers the patient marked and multiply by 5 to base scale out of a possible score of 100 for analysis.

**Symptoms Total** \_\_\_\_\_  
*Multiply total by 5 and enter below.*  
**Patient's N.O.S.E. Score** \_\_\_\_\_

**5-25** Mild Obstruction  
**30-50** Moderate Obstruction  
**55-75** Severe Obstruction  
**80-100** Extreme Obstruction

## 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 \$75 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

**NOTICE OF PRIVACY PRACTICES**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- > Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- > Obtain payment from third-party payers.
- > Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**You have the Right to:**

- \* Get a copy of your medical record
- \* Correct your medical record
- \* Request confidential communication
- \* Ask us to limit information we share
- \* Get a copy of this privacy notice
- \* Choose someone to act for you
- \* Get a list of those with whom we've shared
- \* File a complaint if you believe your privacy rights have been violated

**Your Choices:**

- You have some choices in the way that we use & share information as we:*
- \* Tell Family & Friends about your condition
  - \* Provide disaster relief
  - \* Include you in a hospital directory
  - \* Provide Mental Health Care
  - \* Raise Funds
  - \* Market our services & sell our information

**Our Uses and Disclosures:**

- We may use & share your information as we:*
- \* Treat you
  - \* Run our organization
  - \* Bill for your services
  - \* Help with public health & safety
  - \* Do research
  - \* Comply with the law
  - \* Respond to organ/tissue requests
  - \* Respond to lawsuits/legal actions
  - \* Address workers' compensation, law & government agencies

PRINT Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ (if not signed by Patient)

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this Notice of Acknowledgement, but was unable to do so as documented below:

|       |           |         |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|