Dental Sleep Solutions
of Maryland LLC

Galleria Atrium
1407 York Road, Suite 204
Lutherville, MD 21093
410.821.6458

Enchanted Forest Shopping Center
10030 Baltimore National Pike D120
Ellicott City, MD 21042
410.461.2700

Patient's Clinical History/Family Information

Name _____ _____ Age _____ Sex _____ Date of Birth _____/_____/___
Last First M.I.

Address _____
Street City State Zipcode

Phone Numbers for contact _____
Home Cell Work

Patient's Employer _____ Occupation _____

E-mail for contact _____ May we send a text or e-mail: Yes No

If patient is a minor:

School _____ Grade _____

Father's Name _____ D.O.B. _____
Last First M.I.

Employer _____ Work# _____ Cell# _____

If **father's** information is different from the patient, please indicate: _____
Address _____ Home# _____
Street City Zip

Mother's Name _____ D.O.B. _____
Last First M.I.

Employer _____ Work# _____ Cell# _____

If **mother's** information is different from the patient, please indicate:
Address _____ Home# _____
Street City Zip

Employer _____ Work# _____ Cell# _____

Who is accompanying this child today? Name _____ Relation _____
Do you have legal custody? Yes or No

Primary Insurance Information
Does the patient have insurance coverage? _____ Yes _____ No

Insurance Company _____
Name Phone Number

_____
Address City State Zip Code
Policy Owner _____ DOB _____ Relationship _____
Last First
Employer _____ Group # _____ Policy # _____

Secondary Insurance Information
Insurance Company Name _____ Phone _____
Address _____

Patient's Health Care Provider _____
Name Phone Number

Medical History

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Smoking	—	—			
Rheumatic Fever	—	—	Heart Murmur	—	—
High Blood Pressure	—	—	Heart Attack/Stroke	—	—
Blood Vessel Disease	—	—	Blood Disorder	—	—
AIDS/HIV Infection	—	—	Hepatitis	—	—
Diabetes	—	—	Ulcers	—	—
Herpes (any type)	—	—	Psoriasis	—	—
Cancer	—	—	Persistent Headaches	—	—
Neck Pains	—	—	Nerve or Brain Disease	—	—
Migraine	—	—	Epilepsy	—	—
Mental Health Problems	—	—	Bone Disorders	—	—
Arthritis (any type)	—	—	Sleep Apnea	—	—
Ear Disorder	—	—	Sinus Infection	—	—
Swollen Glands	—	—	Allergies	—	—
Snoring	—	—	GERD	—	—
Insomnia	—	—	TMJ Problems	—	—
Periodontal Disease	—	—	Narcolepsy	—	—
Clenching/bruxing	—	—	Lung Disease	—	—

Is patient under the care of a healthcare provider at present? If yes, why? _____
Is patient currently taking any medications? Include medications for pain and sleeping._____
_____
Is the patient allergic to any medications? If yes, describe. _____
Is the patient pregnant? _____

What is the reason for your visit today?_____
Have you ever seen a health care provider for sleep/breathing disorder?_____
Have you ever had a sleep study? If yes, what year? _____ What were the results?_____
Have you ever worn a CPAP? _____

Dental History

Yes No

Do any of your teeth hurt? If yes, circle area. upper right upper left lower right lower left
Have you ever had any treatment for a periodontal disease (gum disease)? If yes, describe _____
Have you ever had any previous orthodontic treatment? If yes, when and where? _____
Do you clench or grind your teeth? If yes, __while sleeping __under stress __other _____
Do you ever notice tiredness, soreness, tightness or pain in the muscles around the jaws and face? If yes, describe
_____
Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, describe_____
Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____

Whom may we thank for referring you? _____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it to be accurate If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

(Signature of Responsible Adult or Authorized Person) (Date)

I understand and agree that I am completely responsible for payment, despite the fact that I may have insurance coverage. If it becomes necessary to send my account to collections, I understand and agree that treatment will be suspended until my account is current and that I will pay al reasonable fees related to collections, including but not limited to lawyer's fees, court costs and the cost of a private process server to the owed amount. Any unpaid balance would be subject to interest at the annual rate of 15%.

_____ _____

(Signature of Responsible Adult or Authorized Person) (Date)

HIPAA Release of information AUTHORIZATION FORM

I, _____hereby authorize Dental Sleep Solutions of Maryland and its affiliates, its employees and agents to release my personal health information maintained by Dental Sleep Solutions of Maryland (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose o helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other informatic released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longe be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with _____.

I understand that I have a right to revoke this authorization by providing written notice to Dental Sleep Solutions of Maryland. However, this authorization may not be revoked if Dental Sleep Solutions of Maryland, it's employees or agents have taken action or this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____ **Date:**_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Dental Sleep Solutions of Maryland LLC

Bed Partner Questionnaire

To be completed by the patient's bed partner, without influence of the Patient. Please complete and have the Patient bring with them to their appointment.

Patient's Name:_____ Date:_____

Your relationship to Patient:_____

Please estimate how many hours of sleep your bed partner gets:

Sleep Schedule:	**Hours each night:**	**How long does it take for your partner to fall asleep?**	**How long is your partner awake during the night?**
Work days:			
Days off:			

Check any positions your bed partner sleeps in: ☐ **Back** ☐ **Side** ☐ Stomach

Does your bed partner snore? ☐ Never ☐ **Occasionally** ☐ Often ☐ Unknown

If they snore, please check the positions they snore in: ☐ **Back** ☐ Side ☐ Stomach

How loud is his/her snoring? ☐ 1 (Light) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Loud)

Does your bed partner do any of the following in his/her sleep? (Check all that apply)

☐ **Gagging** ☐ **Chocking** ☐ **Snorting** ☐ **Gasping** ☐ **Teeth Grinding** ☐ Kicking their feet

	Never	Occasionally	Often	Unknown
Does your bed partner take naps during the day?				
Is your bed partner restless during sleep?				
Does your bed partner stop breathing in his/her sleep?				
Does your bed partner fall asleep when driving?				
Does your bed partner fall asleep without warning?				
Does your bed partner kick their legs while sleeping?				
Does your bed partner mumble, talk, or yell during sleep?				
Does your bed partner awaken during the night?				

How much stress does your bed partner currently have? ☐1 (Light) ☐2 (moderate) ☐3(A great amount)

Please estimate your bed partner's risk of falling asleep or dozing off in the following situations, using the following scale: 0= No chance 1= Slight chance 2= Moderate chance 3= High chance

Sitting and Reading: ☐0 ☐1 ☐2 ☐3	Lying down to rest in the afternoon: ☐0 ☐1 ☐2 ☐3
Watching TV: ☐0 ☐1 ☐2 ☐3	As a passenger in a car, for an hour with no break: ☐0 ☐ 1 ☐ 2 ☐ 3
Sitting, inactive, in public (Theater, Meetings, etc) ☐0 ☐1 ☐2 ☐3	Sitting quietly after lunch, without alcohol: ☐0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone: ☐0 ☐1 ☐2 ☐3	In a car, stopped in traffic, for a few minutes: ☐0 ☐ 1 ☐ 2 ☐ 3

Has your bed partner's mood, memory, concentration, or personality deteriorated or changed?
☐ yes ☐ no If yes, please explain: _____

_____

_____

Does your bed partner's sleep problems disrupt your sleep? ☐ Never ☐ Occasionally ☐ Often
Please explain: _____

_____

Please use this space for any other information you would like to add.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this form.

Bed Partner Questionnaire