



CENTER FOR
FACIAL PAIN
&
DENTAL SLEEP
MEDICINE, P.C.

Welcome to the Center for Facial Pain & Dental Sleep Medicine, P.C.;

Thank you for considering our office for the diagnosis of your Sleep Disorder. Rest assured that you would have the latest in diagnostic procedures and the skill of a Board Certified doctor in Dental Sleep Medicine. Our highly trained staff will answer any questions that you may have and assist you in an appropriate manner during the history and exam procedure.

Our ability to help you will depend on your thoroughness in filling out the assessment questionnaires you have been sent. We ask that you take some time out of your busy schedule to fill them out completely, honestly and accurately. This will benefit you directly as it greatly enhances the accuracy of our diagnosis for your medical condition. Most Sleep Disorders are complex in nature and require a significant amount of time to understand. There are many interacting factors that influence the symptoms that you are having at this time.

We work very hard to keep our fees as low as possible. One way we accomplish this is by having our patients pay at the time services are rendered. We provide our patients several convenient options: cash, debit cards, check, Visa, MasterCard, American Express, Discover cards and interest free long-term payment plans. We also provide an insurance claim form at the time of each appointment in order to file with your insurance company.

As you fill in the following forms, please be sure to sign at the bottom of pages 2, 4 and 6.

We look forward to meeting you for your scheduled consultation. If you have any questions or concerns, feel free to contact any member of our staff. They will be delighted to assist you.

Sincerely,

Dr. Prehn and Staff

Phone toll free: 866-865-8392; local 715-845-6419 www.sleeplessinwisconsin.com



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DENTAL SLEEP

MEDICINE, P.C. Ronald S. Prehn, D.D.S.

Diplomate of the American Board of Dental Sleep Medicine

413 Jefferson Street
Wausau, Wisconsin 54403
Off: 715-845-6419 Fax: 281-296-6887
Toll free: 866-865-8392

CONFIDENTIAL PATIENT INFORMATION PLEASE PRINT ALL INFORMATION

Name _____

First

Middle

Last

Male

Female

Nickname _____

Married

Single

Minor

Student

Address _____ Home telephone() _____

City _____ State _____ Zip _____ Office telephone() _____

Cell# _____ Email Address _____

Birth date _____ Social Security _____ Drivers Lic. _____

Place of Employment (or school) _____ Address _____

Physician _____ Address _____

City _____ State _____ Zip _____ Telephone() _____

Dentist _____ Address _____

City _____ State _____ Zip _____ Telephone() _____

Spouse name _____

First

Middle

Last

Spouse Birth date _____ Spouse Social Security # _____

Spouse Drivers Lic. _____ Spouse Work #() _____

Spouse Employment _____ Address _____

Responsible Party Information: Same as Patient check this box **OR** if minor fill out the following:

Parent # 1

Name _____

First

Middle

Last

Address _____

City _____ State _____ Zip _____ Home telephone() _____

Office telephone() _____ Birth date _____ Social Security # _____

Texas Drivers Lic. _____

Place of Employment _____ Address _____

Parent # 2

Name _____

First

Middle

Last

Address _____

City _____ State _____ Zip _____ Home telephone() _____

Office telephone() _____ Birth date _____ Social Security # _____

Texas Drivers Lic. _____

Place of Employment _____ Address _____

Whom may we thank for referring you to our office? _____

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE TO MAKE A COPY

PLEASE SIGN AND DATE AT THE BOTTOM

- Please list the names of family members (i.e. spouse), attorney or other persons, if any, whom we may inform about your medical condition, diagnosis and financial responsibility.

- Please list the health care providers whom we may inform about your medical condition.

Referring Doctor: _____
 Dentist: _____
 Physician: _____
 Other: _____

- Please print the address of where you would like your billing statements and/or correspondence from this office sent if other than your mailing address.

Should further information be needed for my treatment with this office, I give consent to ask my respective health care provider or agency, to release any information to you. YES NO

I consent to the use of my medical record for the purpose of educating other healthcare providers. However, my identity will be kept confidential so that I will not be identified. YES NO

We will provide you with the necessary information to follow up with your insurance company.

Please read carefully:

(Your signature below means you agree)

- I understand that all charges incurred in this office are due at the time they are rendered.
- I understand that these fees may exceed the limit allowed by my insurance company.
- I understand that this office is not a provider for my insurance company, including Medicare, Medicaid, Workman’s Comp, Champus or TriCare.
- I understand that I will be responsible to file my claim to my insurance company.
- I authorize the release of medical records or other information needed for the insurance claim form.
- I will be provided with fees prior to receiving treatment and I understand that I have the option to seek treatment from a participating provider.

The name and phone number of your nearest relative or close friend to notify in case of an emergency.

Patient/Guarantor Signature: _____ Date _____

Witness: _____ Date: _____



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Sleep Questionnaire

Your Name: _____ Age: _____ Date of Birth _____

Please check the following questions that apply to you:

- Do you snore? Mild Moderate Severe? How many years? ____
- Do you snore: On your side? on your back? Usual position: back side stomach
- Do you fall asleep when reading, watching TV, or other passive activities?
- Do you fight sleepiness on the job or when driving?
- Do you most often wake with headaches?
- Do you ever wake choking or gasping for air?
- Do you most often wake up feeling tired, fatigued, and unrefreshed?
- Do you take naps during the day? If so, for how long? ____
- Do you have trouble *falling* asleep? On average, how long to go to sleep? _____
- Do you have trouble *staying* asleep throughout the night?
Number of times you wake up at night ____
Length of time getting back to sleep after you wake up at night ____
- Do you have restless or “creepy, crawly” leg feelings?
- Do you experience unusual behaviors just before, during or after sleep?
- Do you ever wake up feeling *paralyzed*?
- Have you ever experienced a sudden loss of strength in your arms/legs during the day?
- Do you feel unhappy or discouraged about your sleep?
- Does your sleep problem affect your family life, work performance?
- How many caffeinated beverages do you have each day? ____
- Do you think you get enough sleep at night? Number of hours of sleep per night ____

Does your bed partner complain of:

- Your loud snoring?
- Your partner sometimes sleep in another room at night because of your snoring?
- Your twitching legs, kicking or excessive moving at night?
- Long breathing pauses during your sleep?

Do you have or ever had the following:

- Jaw popping, clicking or grinding?
- Your jaw ever locked or gotten stuck?
- Been diagnosed with TMJ?
- Been told you grind your teeth at night (brux)?
- Ever had a mouth guard made by a Dentist?
- Pain with chewing?

Rank how likely it would be for you to become drowsy during the day in the following situations:

- 0= Would never doze
 1= Slight chance of dozing
 2= Moderate chance of dozing
 3= High chance of dozing

Epworth Sleepiness Scale

Situation	Chance of dozing
Sitting & Reading	
Watching TV	
Sitting inactive in a public place (i.e. theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, stopped for a few minutes in traffic	
Total score:	

My sleep problems are:

Sleep Medications taken in the last year: (includes nonprescription)

- Do you have high blood pressure?
 Do you any heart problems?
 Do you have type 2 diabetes?
 Do you have acid reflux or wake with heart burn at night or in the morning?
 Do you feel as though you are over your healthy weight?

What is your Ht: _____ Wt: _____

Have you ever had a sleep study? Yes No

If YES, then please have the sleep lab fax results to: 281-296-6887. Thank you.

Patient Signature: _____ Date: _____

HEALTH HISTORY

Patient Name: _____ Birth Date: _____ Date: _____

Chief Concern: _____

Current medications including supplements and vitamins: _____

Review of Systems: Please mark all that apply past or present (many of these concerns may have a direct effect on your problem)

- | | | | |
|---|--|---|--|
| <p>◆ CONSTITUTIONAL SYMPTOMS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Good general health lately <input type="checkbox"/> Recent weight change <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <p>◆ EYES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye disease or injury <input type="checkbox"/> Wear Glasses/contact lenses <input type="checkbox"/> Blurred or double vision <p>◆ EARS/NOSE MOUTH/THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear ringing <input type="checkbox"/> Ear aches or drainage <input type="checkbox"/> Chronic sinus problem <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores <input type="checkbox"/> Bleeding. <input type="checkbox"/> Bad breath or bad taste <input type="checkbox"/> Sore throat <input type="checkbox"/> Voice change <input type="checkbox"/> Swollen glands in neck <p>◆ CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart trouble <input type="checkbox"/> Chest pain or angina pectoris <input type="checkbox"/> Heart palpitation <input type="checkbox"/> Heart murmur <input type="checkbox"/> Swelling: _____
feet/ankles/hands | <p>◆ RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic or frequent coughs <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <p>◆ GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Change in bowel movements <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Painful bowel movements <input type="checkbox"/> Constipation <input type="checkbox"/> Rectal bleeding/ blood in stool <input type="checkbox"/> Abdominal pain <p>◆ GENITOURINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Burning or painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence or dribbling <input type="checkbox"/> Kidney stones <input type="checkbox"/> Male - testicle pain <input type="checkbox"/> Female - pain with periods <input type="checkbox"/> Female - irregular periods <input type="checkbox"/> Female - vaginal discharge <input type="checkbox"/> Female - # of pregnancies <input type="checkbox"/> Other medical conditions not mentioned above?
_____ | <p>◆ MUSCULOSKELETAL (NOT TMJ)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness or swelling <input type="checkbox"/> Weakness of muscles or joints <input type="checkbox"/> Muscle pain or cramps <input type="checkbox"/> Back pain <p>◆ INTEGUMENTARY (SKIN, BREAST)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash or itching <input type="checkbox"/> Change in skin color <input type="checkbox"/> Change in hair or nails <input type="checkbox"/> Varicose veins <input type="checkbox"/> Breast pain <input type="checkbox"/> Breast lump <p>◆ NEUROLOGICAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent/recurring headaches <input type="checkbox"/> Light headed or dizzy <input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Numbness or tingling sensation <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Head injury <p>◆ PSYCHIATRIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Memory loss or confusion <input type="checkbox"/> Anxious <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> <u>Environmental</u> allergies: _____ | <p>◆ ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glandular or hormone problem <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Skin becoming dryer <p>◆ HEMATOLOGIC/ LYMPHATIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleeding or bruising tendency <input type="checkbox"/> Anemia <input type="checkbox"/> Phlebitis <input type="checkbox"/> Past transfusion <input type="checkbox"/> Enlarged glands <p>◆ ALLERGIC/IMMUNOLOGIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of skin reaction or other adverse reaction to: <input type="checkbox"/> Penicillin or other <u>antibiotics</u> <input type="checkbox"/> Morphine, Demerol, or other <u>narcotics</u> <input type="checkbox"/> Novocain or other <u>anesthetics</u> <input type="checkbox"/> Antiinflammatories <input type="checkbox"/> Tetanus antitoxin or other <u>serums</u> <input type="checkbox"/> Iodine, Merthiolate or other <u>antiseptic</u> <input type="checkbox"/> Latex <input type="checkbox"/> Other drugs/medications: _____ <input type="checkbox"/> Known <u>food</u> allergies: _____ |
|---|--|---|--|

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State

