diamond dental
SLEEP SOLUTIONS

Patient Intake Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Name: ________________________________ Preferred Name: ______________

Address: _______________________City/State/Zip:________________________

Date of Birth: ____/____/______ Email: _________________________________

Home phone:______________ Cell: _______________ Work: _____________

Sleep Physician: __________________________ Phone: ___________________

General Physician: ________________________ Phone: ___________________

Dentist: _________________________________Phone: ___________________

Other : _________________________________ Phone:____________________

Concerns:

What Prompted You to Seek Diagnosis and Treatment? Please circle all that apply.

Sleep Apnea
Difficulty Falling Asleep
Morning Headaches
Insomnia
Wake up Gasping/Choking
Nasal Problems
Restless Legs
Neck or Facial Pain
Memory Problems
Snoring
Irritability or Mood Swings
Alternative to CPAP
Excessive Daytime Sleepiness (EDS)
I have been told I stop Breathing When I Sleep

Other:____

How long have you had the problem? ____________

Have you ever had a sleep study performed? Y N How long ago?__________

If yes, please name the provider who conducted your sleep study:

____

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Have you ever tried an Oral Appliance? Y N

If yes, was it fabricated by a dentist? Y N

If yes, who fabricated it? ________________

If applicable, please describe your previous Oral Appliance experience:

____

____

Are you currently or have you ever used a CPAP? Y N

If Yes, how many nights per week do you currently wear it? ____________________

When you wear/wore your CPAP, how many hours per night do/did you wear it? ___

Treatment Will Be Successful When: ____

Dental History:

When was your last dental exam/cleaning? _________________________________

Any unfinished dental work? ____

Any Dental Concerns? ____

How Would You Describe Your Dental Health? Excellent Good Fair Poor

Have You Ever Had Teeth Extracted? Y N

Do You Wear Complete or partial removable dentures? Y N

If Yes, Please Describe: ____

Have You Ever Worn Braces (Orthodontics?) Y N

If Yes, Date Completed: _____________

Have You Ever Had Gum Problems? Y N

If Yes, Have You Ever Had Gum Surgery? Y N

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Do You get Dry Mouth? Y N

Have You Ever Had an Injury to Your Head, Face, or Mouth? Y N

Have you been told You Clench or Grind Your Teeth? Y N

Does Your TMJ (Jaw Joint) Click or Pop? Y N

Do You Have Pain in the jaw joint? Y N

If You Answered Yes to Any Questions Above, Please Briefly Describe Your Answer:

____

____

____

____

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

Daily Occasionally Rarely/Never

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

Daily Occasionally Rarely/Never

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

Daily Occasionally Rarely/Never

Do you smoke? Y N If yes, how many packs per day? _______

Do you use chewing tobacco? Y N If yes, how many times per day? _______

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Patient Authorization, Assignment of Benefits & Financial Agreement

In return for the services provided by Diamond Dental Sleep Solutions, (the "Practice") I understand that all applicable copayments and deductibles are due at the time of service. I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment. I agree to be financially responsible and make full payment for all charges not covered by my insurance company, including in instances where my coverages lapses or if I fail to give the requisite insurance information to the office. I authorize my insurance benefits to be paid directly to the Practice for services rendered. I authorize representatives of the Practice to release pertinent information to my insurance company when requested or to facilitate payment of a claim. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me. In the event I receive payment from the insurance company for services rendered by the Practice and fail to remit such payment to the Practice immediately then I acknowledge and agree that I will be responsible for any fees, including legal fees associated with Dental Sleep Solutions' collection efforts from me. If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. If my account is delinquent, I may be charged interest at the legal rate. I agree to be primarily responsible for the payment of the Practice's bill.

I read and agree to all of the above.

Beneficiary Signature or Authorized Party: ___________________________________

Date:_____________