diamond dental
SLEEP SOLUTIONS

Patient Intake Form

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Introductions:

Name: _____ Preferred Name: _____

Address: _____City/State/Zip:_____

Date of Birth: ____/____/_____ Best Contact Phone: (H C W): _____

Email: _____ *This information will not be shared*

Sleep Physician: _____ Phone: _____

General Physician: _____ Phone: _____

Dentist: _____Phone: _____

Other : _____ Phone:_____

Concerns:

What Prompted You to Seek Diagnosis and Treatment?

_____

Sleep Apnea Snoring Alternative to CPAP

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

Any Use of Oral Appliance? Y N Temporary/Trial _____

Jaw Joint Problems? None Pain Limitations: _____

When was your last dental exam/cleaning? _____

Any Dental Treatments Recommended? _____

Other Dental Concerns: _____

Any Other Concerns: _____

Treatment Will Be Successful When: _____