

Dr. Gregg Ueckert - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: _____
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
The best time to contact me is: Morning Mid-Day Evening on Home phone Cell phone Work phone
Email Address _____ Would you like to receive our e-newsletter? Yes No
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth (M/D/Y): ____/____/____ Gender: M F Social Security Number (SSN): _____
Height: Feet ____ Inches ____ Weight (lbs): ____ Marital Status: Married Single Life Partner Minor
Spouse or Parent/Guardian (if minor) Name: _____
Emergency Contact: _____ Relationship: _____ Phone _____
REFERRED BY: _____

Employer Information

Employer: _____ Phone: (____) _____ Fax: (____) _____
Address: _____ City _____ State: _____ Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: Self Spouse Child Other
Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____/____/____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address _____ City _____ State: _____ Zip _____
Phone: (____) _____ Fax: (____) _____ Email: _____
Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? YES NO IF YES, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: Self Spouse Child Other
Name of Insured (First, MI, Last): _____ Insured DOB ____/____/____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address _____ City _____ State: _____ Zip _____
Phone: (____) _____ Fax: (____) _____ Email: _____
Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____
ENT: _____ Phone: _____
SLEEP DOCTOR: _____ Phone: _____
DENTIST: _____ Phone: _____
OTHER MD: _____ Phone: _____
OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INITIAL: _____
Date: _____

Dr. Gregg Ueckert Patient Questionnaire

EPWORTH SLEEPINESS SCALE

Sitting and Reading _____
 Watching TV _____
 Sitting inactive in public place (theater) _____
 As a car passenger for an hour without a break _____
 Lying down in the afternoon to rest _____
 Sitting and talking to someone _____
 Sitting quietly after lunch without alcohol _____
 In a car while stopped at a traffic light _____

0 = No chance of dozing
 1 = Slight Chance of dozing
 2 = Moderate Chance of dozing
 3 = High Chance of dozing

TOTAL = _____

THORNTON SNORING SCALE

My snoring affects my relationship with my partner _____
 My snoring causes my partner to be irritable or tired _____
 My snoring requires us to sleep in separate rooms _____
 My snoring is loud _____
 My snoring affects people when I am sleeping away from home _____

0 = Never
 1 = 1 night/week
 2 = 2-3 nights/week
 3 = 4+ nights/week

TOTAL = _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

Do you have other complaints?

- | | |
|---|--|
| <input type="checkbox"/> Frequent snoring | <input type="checkbox"/> Difficulty maintaining sleep |
| <input type="checkbox"/> Excessive Daytime Sleepiness (EDS) | <input type="checkbox"/> Choking while sleeping |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Feeling unrefreshed in the morning |
| <input type="checkbox"/> Waking up gasping / choking | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Neck or facial pain | <input type="checkbox"/> Nasal problems, difficulty breathing through nose |
| <input type="checkbox"/> I have been told I stop breathing when I sleep | <input type="checkbox"/> Irritability or mood swings |
| <input type="checkbox"/> Other: _____ | |

Subjective Signs and Symptoms

- Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)
- Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)
- Have you been told you snore? YES / NO / SOMETIMES
- Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)
- On average, how many times per night do you wake up? _____
- On average, how many hours of sleep do you get per night? _____
- How often do you awaken with headaches? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY
- Do you have a bed partner? YES / NO / SOMETIMES Do you sleep in the same room? YES / NO
- How many times per night does your bedtime partner notice you stop breathing?
 SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER

Dr. Gregg Ueckert Patient Questionnaire

Have you ever had a sleep study? YES NO

If YES, where and when? _____ Date: _____

Have you tried CPAP? YES NO

Are you currently using CPAP? YES NO

If YES, how many nights per week do you wear it? _____ / 7 Nights

When you wear your CPAP, how many hours per night do you wear it? _____ hours per night

If you use or have used CPAP, what are your chief complaints about CPAP?

- | | |
|--|--|
| <input type="checkbox"/> Mask leaks | <input type="checkbox"/> Device causes claustrophobia or panic attacks |
| <input type="checkbox"/> An inability to get the mask to fit properly | <input type="checkbox"/> An unconscious need to remove CPAP at night |
| <input type="checkbox"/> Discomfort from the straps or headgear | <input type="checkbox"/> Caused GI / stomach / intestinal problems |
| <input type="checkbox"/> Decrease sleep quality or interrupted sleep from CPAP device | <input type="checkbox"/> CPAP device irritated my nasal passages |
| <input type="checkbox"/> Noise from the device disrupting sleep and/or bedtime partner's sleep | <input type="checkbox"/> Inability to wear due to nasal problems |
| <input type="checkbox"/> CPAP restricted movement during sleep | <input type="checkbox"/> Causes dry nose or dry mouth |
| <input type="checkbox"/> CPAP seems to be ineffective | <input type="checkbox"/> The device causes irritation due to air leaks |
| <input type="checkbox"/> Device causes teeth or jaw problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> A latex allergy | _____ |

Are you currently wearing a dental device? YES NO

Have you previously tried a dental device? YES NO

If YES, was it Over the Counter (OTC)? YES NO

Was it fabricated by a dentist? YES NO If YES, who fabricated it? _____

If applicable, please describe your previous dental device experience:

Have you ever had surgery for snoring or sleep apnea? YES NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: _____ SURGEON: _____ SURGERY: _____

DATE: _____ SURGEON: _____ SURGERY: _____

DATE: _____ SURGEON: _____ SURGERY: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.

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PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures? YES NO
If YES, what medication(s) and why do you require it? _____

ALLERGENS -- Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

MEDICATIONS – Please list all medications you are currently taking:

MEDICAL HISTORY – Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

Dental History

How would you describe your dental health? EXCELLENT GOOD FAIR POOR

Have you ever had teeth extracted? YES NO → If YES, please describe _____

Do you wear removable partials? YES NO

Do you wear full dentures? YES NO

Have you ever worn braces (orthodontics)? YES NO → If YES, date completed: _____

Does your TMJ (jaw joint) click or pop? YES NO → Do you have pain in this joint? YES NO

Have you had TMJ (jaw joint) surgery? YES NO

Have you ever had gum problems? YES NO → If YES, have you ever had gum surgery? YES NO

Do you have dry mouth? YES NO

Have you ever had an injury to your head, face, neck, or mouth? YES NO

Are you planning to have dental work done in the near future? YES NO

Do you clench or grind your teeth? YES NO

If you answered YES to any question above, please briefly describe your answer here:

Family History

Have genetic members of your family had:

Heart Disease? YES NO High Blood Pressure? YES NO Diabetes? YES NO

Have genetic members of your family been diagnosed or treated for a sleep disorder? YES NO

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? YES NO If YES, how many packs per day? _____

Do you use chewing tobacco? YES NO If YES, how many times per day? _____

PATIENT SIGNATURE

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.
Patient or Guardian Signature: _____ Date: _____