

**Registration for Patients With Obstructive Sleep Apnea and Snoring**

**B. Gail Demko D.M.D.**

www.SleepApneaDentist.com

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: home: \_\_\_\_\_ work \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital status: \_\_\_\_\_

Employed by: \_\_\_\_\_

Medical Insurance Co: \_\_\_\_\_

Medical Insurance subscriber # \_\_\_\_\_

Name of Subscriber( if other than patient): \_\_\_\_\_

Date of Birth of Subscriber: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Secondary Medical Insurance Co. \_\_\_\_\_

Insurance Subscriber: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Name of person who referred you to the practice? \_\_\_\_\_

Sleep Physician's name: \_\_\_\_\_

Office address: \_\_\_\_\_

Office telephone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Office address: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Office address: \_\_\_\_\_

Date of last exam: \_\_\_\_\_ Did you have braces? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Have you had an over night sleep study? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If so, when? \_\_\_\_\_

Do you snore? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Don't Know: \_\_\_\_\_

Have you gained weight in the past year? Yes: \_\_\_\_\_ No: \_\_\_\_\_. If so, how much? \_\_\_\_\_ lbs

Have you used CPAP? Yes: \_\_\_\_\_ No: \_\_\_\_\_ How long? \_\_\_\_\_ Pressure level: \_\_\_\_\_

If any, the reason for stopping: \_\_\_\_\_

How often do you use it? :

Nightly: \_\_\_\_\_ 3 -6 Nights a week: \_\_\_\_\_ 1-3 nights a week: \_\_\_\_\_ rarely: \_\_\_\_\_

Have you had an evaluation with an Ear Nose and Throat MD? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Have you had any throat or nose surgery? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you have daytime sleepiness? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Is there a family history of snoring? Yes: \_\_\_\_\_ No: \_\_\_\_\_

How often do you awaken at night? \_\_\_\_\_

I hereby authorize payment be made directly to B. Gail Demko, DMD PC. for services provided to me.

I allow the release of pertinent medical records to my insurance company and my other medical providers:

Signature of Patient \_\_\_\_\_

Date: \_\_\_\_\_

**HMO PATIENTS: I understand it is my (the patients) responsibility to obtain referrals PRIOR to my visit and that co-pays are my contractual responsibility and payable at the time of my visit.**

Signature of patient \_\_\_\_\_ Date: \_\_\_\_\_