the Gelb center
Headaches, TMJ, and Sleep Disorders

Patient Registration

FORM DATE: ____/____/_____

Patient ID: _____ Chart ID: _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ _____

First Name **Middle Initial** **Last Name**

Primary Care Physician

Responsible Party (If someone other than patient)

Name

Patient Information

Street Address

City State Zip

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ____/____/_____ Social Security Number _____-_____-_____

E-mail Spouse Name

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: ___ Feet ___ Inches

☐ Allow Spouse to Review Records

Family Dentist

Medical Insurance Information

Primary Medical Insurance Information

First Name of Insured: Last Name Middle Initial ___

Policy/Group No. Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID No. Insured Birth Date ____/____/_____ Plan Name

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Secondary Medical Insurance Information

First Name of Insured: Last Name Middle Initial

Policy/Group No. Insurance Plan or Program Name

Insured Birth Date ____/____/_____ Sex: ☐ Male ☐ Female Insurance ID No.

Employer Ins. Company

Insured Address if different than patient's

Street Address Street Address

City, State, Zip City, State, Zip

Patient Signature: Date:

Medical History Questionnaire

NAME: _____ __ _____

FORM DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____

Allergens

- ☐ Antibiotics
- ☐ Local anesthetics
- ☐ Sulfa drugs
- ☐ No known allergies
- ☐ Penicillin
- ☐ Other
- ☐ Latex

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Medical questions					
Do yu have any of the following medical conditions?			☐ Yes	☐ No	Migraine headaches
☐ Yes	☐ No	Acid reflex or GERD?	☐ Yes	☐ No	Emphysema or COPD
☐ Yes	☐ No	Autoimmune disorder	☐ Yes	☐ No	Nighttme sweating
☐ Yes	☐ No	Asthma or wheezing	☐ Yes	☐ No	Epilepsy or seizures
☐ Yes	☐ No	Chronic sinus problems	☐ Yes	☐ No	Recent excessive weight gain
☐ Yes	☐ No	Chronic fatigue	☐ Yes	☐ No	Heartburn
☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Thyroid problems
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	High blood pressure
☐ Yes	☐ No	Insomnia	☐ Yes	☐ No	Tonsillectomy
☐ Yes	☐ No	Difficulty concentrating	☐ Yes	☐ No	High cholesterol
☐ Yes	☐ No	Memory loss	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Dizziness			

Please ist any significant medical issues below:

Other

Patient Signature: _____ Date: _____

Family History

Has any member of your family (parent, sibling, or grandparent) had:

- ☐ Yes ☐ No Heart disease
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Diabetes

Have any members been diagnosed or treated for a sleep disorder?

- ☐ Yes ☐ No Sleep apnea

SOCIAL HISTORY:

Alcohol consumption:

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

- ☐ never
- ☐ once a week
- ☐ several times a week
- ☐ daily
- ☐ occaionally
- ☐ _____

- ☐ Drinking DOES make me snore worse
- ☐ Drinking does NOT make me snore worse

Sedative consumption

How often do you take sedative within 2-3 hous of bedtime?

- ☐ never
- ☐ once a week
- ☐ several times a week
- ☐ daily
- ☐ occasionally
- ☐ _____

Caffeine consumption:

How often do you consume caffeinated drinks within 2-3 hours of bedtime? (this includes coffee, tea, sodas, sports drinks, and "alertness" drinks)

- ☐ never
- ☐ once a week
- ☐ several times a week
- ☐ daily
- ☐ occasionally
- ☐ _____

- ☐ Yes
- ☐ No

Do yu smoke? If so how much? And what?

- ☐ Yes
- ☐ No

Do you chew tobacco?

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____

Comprehensive Questionnaire
(Sleep/TMD/Perio/Implant/Ortho)

NAME: _____ __ _____ CURRENT DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

Referring Physician: Contact ID:

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number #1 = the most severe symptom	Frequency 1-4	Intensity 1-10	Number #1 = the most severe symptom	Frequency 1-4	Intensity 1-10
_ Headaches			_ Gasping when Waking Up		
_ Cluster Heaches			_ Nighttime Choking Spells		
_ Migraines			_ Feeling unrefreshed upon waking		
_ Ear pain			_ Obstructive Sleep Apnea		
_ Ringing in the Ears			_ Neurocognitive Deficits		
_ Jaw Locking			_ Difficulty Swallowing		
_ Teeth Grinding			_ Facial Pain		
_ Teeth Clenching			_ Jaw Clicking/Popping		
_ Neck Pain			_ Pain when Chewing		
_ Frequent Heavy Snoring			_ Jaw Pain		
_ Significant Daytime Drowsiness					

Other: Write In

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Patient Signature: Date:

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

DATE OF ACCIDENT OR INCIDENT:

Enter date (month/day/year)

THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

Select one:

- ☐ A motor vehicle accident
- ☐ A motorcycle accident
- ☐ A work related incident
- ☐ A playground incident
- ☐ An athletic endeavor
- ☐ A fight
- ☐ A fall
- ☐ An accident
- ☐ Hit by an object
- ☐ Hit an object
- ☐ An illness
- ☐ An injury
- ☐ Orthodontics
- ☐ Dental procedures
- ☐ Whiplash
- Other:

HISTORY OF ACCIDENT

Patient Signature: Date:

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

WERE YOU:

Select one:

- ☐ A passenger in a motor vehicle
- ☐ The driver of a vehicle
- ☐ A pedestrian
- ☐ At work
- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ Did you hit an object?
- Other:

Patient Signature: Date:

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

- ☐ At the front end
- ☐ At the rear end
- ☐ At the front right area
- ☐ At the front leftt area
- ☐ At the rear right area
- ☐ At the rear left area
- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- Other area: ☐

INDICATE IF THERE WAS ANY TRAUMA:

The patient's:

- ☐ Forehead
- ☐ Face
- ☐ Chin
- ☐ Side of head
- ☐ Back of head
- ☐ Top of head
- ☐ Teeth
- ☐ Jaw
- Other: ☐

Forcibly struck the:

- ☐ Steering wheel
- ☐ Windshield
- ☐ Passenger's side window
- ☐ Driver's side window
- ☐ Passenger's side door
- ☐ Driver's side door
- ☐ Headreast
- ☐ Seat
- ☐ Roof
- ☐ Interior of the car
- Other: ☐

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV

Patient Signature: ☐ Date: ☐

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theater or a meeting)
☐	☐	☐	☐	As a passenger in a car for an hour without a break
☐	☐	☐	☐	Lying down to rest in the afternoon when circumstances permit
☐	☐	☐	☐	Sitting and talking to someone
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: _____

Sleep Study Date: ____/____/_____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of _____

The evaluation showed:

		during REM	*Supine*	*Side*
an RDI of	_	_	_	_
an AHI of	_	_	_	_

a nadir SpO_2 of _ T90 _ ODI _ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Additional Questions

☐ Yes ☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: _____

Affidavit for Intolerance or Non Compliance to CPAP

I, _____, have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (CSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- ❑ Mask Leaks
- ❑ An Inability to get the mask to fit properly
- ❑ Discomfort caused by the straps and headgear
- ❑ Disturbed or interrupted sleep caused by the presence of the device
- ❑ Noise from the device disturbing sleep or bed partner's sleep
- ❑ CPAP restricted movements during sleep
- ❑ CPAP does not seem to be effective
- ❑ Pressure on the upper lip causes tooth related problems
- ❑ Latex allergy
- ❑ Claustrophobic associations
- ❑ An unconscious need to remove the CPAP apparatus at night
- ❑ Other

Because of my intolerance/ inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Signed: _____

Dated: _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

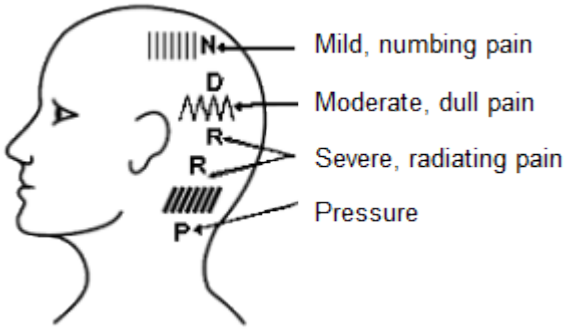
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

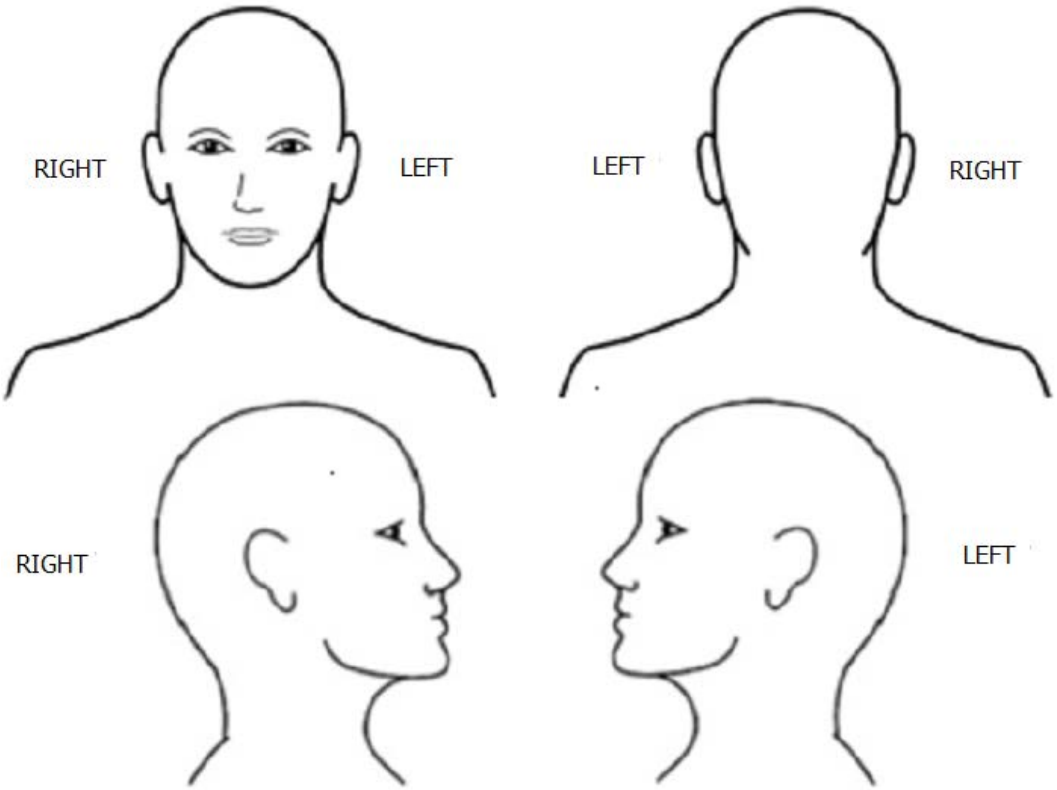
MILD PAIN |||||||

MODERATE PAIN ^^^^

SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating





Enter any text to appear below the image:

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: Date:

I certify that the medical history information is complete and accurate.

Patient Signature: Date: