

Kevin M. Easley D.M.D., P.C.

PATIENT INFORMATION

PATIENT NAME: _____ AKDL# _____

BIRTHDATE: _____ SS#: _____ SEX: MALE OR FEMALE

RELATIONSHIP STATUS: MARRIED SINGLE DIVORCED WIDOWED

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER PHONE: _____

NAME OF SPOUSE / PARENT: _____

SPOUSE / PARENT EMPLOYER: _____

INSURANCE INFORMATION

PRIMARY INS. CO. _____ GROUP #: _____

INSURANCE ADDRESS: _____ EMPLOYER: _____

POLICY HOLDER: _____ BIRTHDATE _____ SS# _____

SECONDARY INS. CO. _____ GROUP #: _____

INSURANCE ADDRESS: _____ EMPLOYER: _____

POLICY HOLDER: _____ BIRTHDATE _____ SS# _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

PAST MEDICAL HISTORY INTAKE

Who referred you to our office? _____

Who is your Primary Care Physician? (If different than referring provider) _____

Chief complaint (why are you here today?) _____

Have you or has any family member experienced any of the following? Please **check** the appropriate box:

| | Self | Mother | Father | Sister | Brother |
|---|------|--------|--------|--------|---------|
| Diabetes | | | | | |
| High blood pressure | | | | | |
| Kidney or bladder disorder | | | | | |
| Asthma | | | | | |
| COPD | | | | | |
| Chronic pain | | | | | |
| Heart disease, heart surgeries, or other heart problems (like congestive heart failure, A-Fib, or heart attack) | | | | | |
| Stroke or warning stroke | | | | | |
| Substance Abuse | | | | | |
| Sleep Apnea | | | | | |
| Depression / Mental Illness | | | | | |
| Acid reflux | | | | | |
| Other | | | | | |
| Age at Death | | | | | |

List all other medical conditions _____

MAJOR HOSPITALIZATIONS

| Year | Operation or Illness | Name of Hospital | City and State |
|------|----------------------|------------------|----------------|
| | | | |
| | | | |
| | | | |

SOCIAL HISTORY

Occupation: _____ Marital status (circle one): Single Married Divorced Widowed

How many children do you have, and how old are they? _____

Do you consume alcohol? Yes / no If yes, write type and amount per week: _____

Do you smoke? Yes / no If yes, write type and amount per day: _____

Do you chew tobacco? Yes / no If yes, write frequency _____

Do you exercise? Yes / no If yes, write type and frequency: _____

Do you consume caffeine (including caffeinated beverages such as energy drinks, coffee, tea, or cola)? If yes, write type and frequency _____

What time do you usually eat your last meal of the day? _____

REVIEW OF SYSTEMS

| | |
|--|---|
| Constitutional <input type="checkbox"/> normal <input type="checkbox"/> undernourished <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> recent weight change | Musculoskeletal <input type="checkbox"/> normal <input type="checkbox"/> weakness <input type="checkbox"/> cramps <input type="checkbox"/> joint stiffness/swelling <input type="checkbox"/> joint/back pain |
| Eyes <input type="checkbox"/> normal <input type="checkbox"/> blindness <input type="checkbox"/> corrective lenses <input type="checkbox"/> blurred or double vision <input type="checkbox"/> dry eyes | Integumentary (skin) <input type="checkbox"/> normal <input type="checkbox"/> dry <input type="checkbox"/> rash <input type="checkbox"/> change in color/texture <input type="checkbox"/> varicose veins |
| Ears/Nose/Throat <input type="checkbox"/> normal <input type="checkbox"/> hearing loss <input type="checkbox"/> nosebleed <input type="checkbox"/> hoarseness <input type="checkbox"/> swollen neck glands <input type="checkbox"/> chronic nasal congestion | Allergic/Immunologic <input type="checkbox"/> no known allergies <input type="checkbox"/> food allergy <input type="checkbox"/> medication allergy <input type="checkbox"/> immune deficiency |
| Cardiovascular <input type="checkbox"/> normal <input type="checkbox"/> chest pain <input type="checkbox"/> palpitation <input type="checkbox"/> irregular rhythm <input type="checkbox"/> swelling of extremities <input type="checkbox"/> high blood pressure <input type="checkbox"/> congestive heart failure | Endocrine <input type="checkbox"/> normal <input type="checkbox"/> excessive thirst <input type="checkbox"/> diabetes <input type="checkbox"/> excessive hunger <input type="checkbox"/> heat/cold intolerance <input type="checkbox"/> known glandular/hormone issues |
| Respiratory <input type="checkbox"/> normal <input type="checkbox"/> chronic cough <input type="checkbox"/> COPD <input type="checkbox"/> asthma <input type="checkbox"/> short of breath <input type="checkbox"/> wheezing <input type="checkbox"/> TB | Hematological/Lymph <input type="checkbox"/> normal <input type="checkbox"/> anemia <input type="checkbox"/> easy bleeding/bruising <input type="checkbox"/> swollen lymph nodes |
| Gastro-Intestinal <input type="checkbox"/> normal <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> rectal bleeding <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> jaundice <input type="checkbox"/> heartburn | Neurological <input type="checkbox"/> normal <input type="checkbox"/> dizziness <input type="checkbox"/> stroke <input type="checkbox"/> syncope <input type="checkbox"/> frequent headache <input type="checkbox"/> migraines <input type="checkbox"/> seizures <input type="checkbox"/> numbness <input type="checkbox"/> paralysis <input type="checkbox"/> tremors |
| Genito-Urinary <input type="checkbox"/> normal <input type="checkbox"/> pain with urination <input type="checkbox"/> urgency <input type="checkbox"/> blood in urine <input type="checkbox"/> incontinence/dribbling <input type="checkbox"/> testicle pain <input type="checkbox"/> menstrual pain | Psychological <input type="checkbox"/> normal <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> insomnia <input type="checkbox"/> memory loss/confusion <input type="checkbox"/> dementia <input type="checkbox"/> drug/alcohol abuse |

SLEEP QUESTIONS

On weekdays, I usually go to sleep at _____ and wake at _____.

On weekends, I usually go to sleep at _____ and wake at _____.

On average it takes me _____ minutes to fall asleep.

I need _____ hours of sleep to feel rested in the morning.

How many times (on average) do you usually get up to urinate during the night? _____

Do you snore or have you been told that you snore? Yes / no

Do you feel sleepy during the daytime? Yes / no

Do you feel like your sleep is "restful" such that you feel restored in the morning? Yes / no

Please **check** the appropriate box:

What is your weight now? _____ Lbs. 1 year ago? _____ Lbs. 5 years ago? _____ Lbs.

| | Never | Rarely | Occasionally | Frequently |
|---|-------|--------|--------------|------------|
| Have you ever been told you stop breathing in your sleep? | | | | |
| Does chest pain or shortness of breath disturb your sleep? | | | | |
| How often do you wake up choking or gasping for air? | | | | |
| Do you ever wake up with headaches? | | | | |
| Do you ever wake up with acid heartburn or a sour taste? | | | | |
| Do you ever wake up with a dry mouth? | | | | |
| Does restlessness in your legs ever prevent you from sleeping? | | | | |
| Do your legs ever twitch or kick while you sleep? | | | | |
| Do you ever act out your dreams (while sleeping)? | | | | |
| Do you ever feel paralyzed upon waking from sleep? | | | | |
| Do you ever experience vivid dreams in naps? | | | | |
| Do you ever get weak or wobbly knees during extreme anger, hard laughing, or while surprised? | | | | |
| Do you ever grind your teeth at night? | | | | |
| Do you ever have visual or auditory hallucinations while sleeping? | | | | |
| Do you take sleeping pills or alcohol in order to sleep? | | | | |

What is your height? _____ Ft. _____ in.

What is your shirt collar size? _____ In.

What size pants do you wear (waist)? _____ In.

NAPPING AND DROWSINESS

How many purposeful naps do you take a day? _____ During a typical week? _____

How often do you accidentally doze off during an average day? _____ Week _____

Do you have difficulty focusing or concentrating in the daytime? Yes / no

In the last 3 years, have you caused an accident by falling asleep when driving? Yes / no

Do you have any difficulty falling asleep at night? Yes / no

Have you had a sleep lab study? Yes / no

Do you have difficulty breathing through your nose? Yes / no

What professional advice or treatment have you received about your snoring or sleep apnea?

DROWSINESS RATING SCALE

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how these activities would have affected you.

Use the following scale and indicate your chances of dozing:

(0) Never doze **(1)** Slight chance of dozing **(2)** Moderate chance of dozing **(3)** High chance of dozing

| | Rating |
|--|--------|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive in a public place (e.g., a theater or 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 lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |
| | |
| EDSS Total | |

Analyze Your Score

Interpretation

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention

FOSQ-10 (Functional Outcomes of Sleep Quality)

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q7. Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q10. Has your mood been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

I verify that the above information is true and accurate to the best of my knowledge.

X _____
Signature of patient (or parent if patient is a minor)

Date

Bed Partner/Witness Screening Questionnaire Obstructive Sleep Apnea

Individual completing form: _____ Date: ____/____/____

Please answer the following questions as they pertain to your bed partner in the past month.

1. While sleeping, does your partner:

- | | | | |
|---|----------------------------|----------------------------|-----------------------------|
| Snore more than half the time? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Always snores? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Snore loudly? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Have "heavy" or loud breathing? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Have trouble breathing, or struggle to breathe? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |

2. Have you ever seen your partner stop breathing during the night?

Y N DK

3. Does your bed partner ever have snorting or choking episodes during the night?

Y N DK

4. Does your partner:

- | | | | |
|---|----------------------------|----------------------------|-----------------------------|
| Tend to breathe through the mouth? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Have a dry mouth on waking up in the morning? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Occasionally wet the bed? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |

5. Have you ever experienced you partner:

- | | | | |
|--|----------------------------|----------------------------|-----------------------------|
| Grinding their teeth during the night? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Have twitching or kicking of their legs or arms? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |

6. Does your partner:

- | | | | |
|--|----------------------------|----------------------------|-----------------------------|
| Wake up feeling unrefreshed in the morning? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Have a problem with sleepiness during the day? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |

7. Has a friend, co-worker or supervisor commented that your partner appears sleepy during the day?

Y N DK

8. Is it hard to wake your partner up in the morning?

Y N DK

9. Does your partner wake up with headaches in the morning?

Y N DK

10. Is your partner overweight?

Y N DK

Affidavit for Intolerance to CPAP

I have attempted to use a PAP machine to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons:

- An inability to get mask to fit properly
 - An unconscious need to remove CPAP apparatus @ night
 - Claustrophobic
 - CPAP does not seem to be effective
 - CPAP restricts movements during sleep
 - Discomfort caused by the straps and/or headgear
 - Disturbed/interrupted sleep caused by presence of device
 - Latex allergy
 - Mask leaks
 - Noise from device disturbing sleep or bed partner's sleep
 - Pressure on upper lip causing teeth related problems
 - Other _____
-

Because of the intolerance and inability to use the PAP, I wish to have an alternative method of treatment. The alternate form of treatment is with a mandibular advancement device (MAD).

Signed _____ Date _____
Patient

Signed _____ Date _____
Dr. Kevin M. Easley

FINANCIAL AND CANCELLATION POLICY

Dr. Kevin M. Easley DMD, PC

Payment is expected at the time of service. We accept all major credit cards (ask us about “extra credit”). Insurance billing is available as a courtesy. You are expected to pay your co-payment and any non-covered services at the time of service. We can only estimate your co-pay, but understand that you are responsible for all charges that the insurance company does not cover. We reserve the right to request a pre-treatment deposit on large cases. This deposit amount will be discussed when proposed treatment is presented.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I, _____, authorize treatment. I agree to promptly pay all fees and charges for treatment provided to me and/or my family. I have read the policies above and understand them.

Insurance payment for services rendered should be assigned to Dr. Easley’s office. I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full. I understand that I am responsible for all charges; whether or not they are covered by my insurance.

I authorize this office to release to my insurance carrier any medical/dental information needed to obtain payment for services rendered. I understand that if I disagree with the charges I will contact this office within 30 days of the billing date. Any past due balance forwarded to DCS Collections will have an additional fee added.

APPOINTMENT CANCELLATION AGREEMENT

We charge a cancellation fee for all appointments that are not cancelled more than 24 hours in advance. This cancellation fee will be 25% of the treatment scheduled. We will request a credit card number to keep on file when long appointments are scheduled and a charge will be made in the event of cancellation. Multiple cancellations without 24 hour notice may result in dismissal from Dr. Easley’s office.

I, _____, understand and agree to the above cancellation agreement.

RESPONSIBLE PARTY SIGNATURE

DATE

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Kevin M. Easley D.M.D., P.C

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

You may leave a message regarding my personal health information on my answering machine/voicemail.

Home Phone _____ or cell _____

Work Phone _____