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._____ ID #: _____

INSURANCE ADDRESS:_____EMPLOYER:_____

POLICY HOLDER:_____BIRTHDATE_____SS#_____

SECONDARY INS. CO. _____ID #: _____

INSURANCE ADDRESS:_____EMPLOYER:_____

POLICY HOLDER:_____BIRTHDATE_____SS#_____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

PAST MEDICAL HISTORY INTAKE

Who is your Primary Care _____
Provider and Dentist? _____
Whom may we thank for referring you to our office? _____

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

Allergies to Medications: Please list each allergy and the reaction you had to that medicine.

1)_____ 2) _____

3)_____ 4) _____

LIST OF CURRENT MEDICATIONS:

Do you take prescription narcotic medication for pain? This includes narcotic pain medications like Vicodin, Percocet, and Oxycontin. Please list all prescription pain medications below, even if you only take them occasionally.

Name of Medication	Strength	How many do you take, and how often do you take?

List all other tablets, patches, drops, ointments, injections, etc. Include prescription, over the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin). You may choose to attach a separate list, if necessary.

Name of Medication	Strength	How many do you take, and how often do you take?

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 ☐ normal ☐ undernourished ☐ fever ☐ chills ☐ recent weight change	**Musculoskeletal** ☐ normal ☐ weakness ☐ cramps ☐ joint stiffness/swelling ☐ joint/back pain
Eyes ☐ normal ☐ blindness ☐ corrective lenses ☐ blurred or double vision ☐ dry eyes	**Integumentary (skin)** ☐ normal ☐ dry ☐ rash ☐ change in color/texture ☐ varicose veins
Ears/Nose/Throat ☐ normal ☐ hearing loss ☐ nosebleed ☐ hoarseness ☐ swollen neck glands ☐ chronic nasal congestion	**Allergic/Immunologic** ☐ no known allergies ☐ food allergy ☐ medication allergy ☐ immune deficiency
Cardiovascular ☐ normal ☐ chest pain ☐ palpitation ☐ irregular rhythm ☐ swelling of extremities ☐ high blood pressure ☐ congestive heart failure	**Endocrine** ☐ normal ☐ excessive thirst ☐ diabetes ☐ excessive hunger ☐ heat/cold intolerance ☐ known glandular/hormone issues
Respiratory ☐ normal ☐ chronic cough ☐ COPD ☐ asthma ☐ short of breath ☐ wheezing ☐ TB	**Hematological/Lymph** ☐ normal ☐ anemia ☐ easy bleeding/bruising ☐ swollen lymph nodes
Gastro-Intestinal ☐ normal ☐ nausea ☐ vomiting ☐ abdominal pain ☐ diarrhea ☐ constipation ☐ rectal bleeding ☐ difficulty swallowing ☐ jaundice ☐ heartburn	**Neurological** ☐ normal ☐ dizziness ☐ stroke ☐ syncope ☐ frequent headache ☐ migraines ☐ seizures ☐ numbness ☐ paralysis ☐ tremors
Genito-Urinary ☐ normal ☐ pain with urination ☐ urgency ☐ blood in urine ☐ incontinence/dribbling ☐ testicle pain ☐ menstrual pain	**Psychological** ☐ normal ☐ depression ☐ anxiety ☐ insomnia ☐ memory loss/confusion ☐ dementia ☐ 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?	☐ **Y**	☐ **N**	☐ **DK**
Always snores?	☐ **Y**	☐ **N**	☐ **DK**
Snore loudly?	☐ **Y**	☐ **N**	☐ **DK**
Have "heavy" or loud breathing**?**	☐ **Y**	☐ **N**	☐ **DK**
Have trouble breathing, or struggle to breathe?	☐ **Y**	☐ **N**	☐ **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?	☐ **Y**	☐ **N**	☐ **DK**
Have a dry mouth on waking up in the morning?	☐ **Y**	☐ **N**	☐ **DK**
Occasionally wet the bed?	☐ **Y**	☐ **N**	☐ **DK**

5. Have you ever experienced you partner:

Grinding their teeth during the night?	☐ **Y**	☐ **N**	☐ **DK**
Have twitching or kicking of their legs or arms?	☐ **Y**	☐ **N**	☐ **DK**

6. Does your partner:

Wake up feeling unrefreshed in the morning?	☐ **Y**	☐ **N**	☐ **DK**
Have a problem with sleepiness during the day?	☐ **Y**	☐ **N**	☐ **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**

Statement of Sleep Apnea Therapy

☐ **I have mild or moderate sleep apnea and per the American Academy of Sleep Medicine, CMS Guidelines and insurance policy, I would like to use oral appliance therapy as first line treatment.**

☐ **I am unable to use the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following marked 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

☐ Latex Allergy

☐ Claustrophobic Associations

☐ An Unconscious Need to Remove the CPAP Apparatus at Night

☐ I Would Like to Use Oral Appliance Therapy in Conjunction with CPAP Therapy to Reduce the CPAP Pressure.

☐ Other _____

Signed _____

Date _____

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_____

Kevin M Easley, DMD, PC

3003 Minnesota Drive, Suite 200
Anchorage, Alaska 99503
(907) 248-0022 (Fax) (907) 677-2552

RELEASE AUTHORIZATION

NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

SS#: _____

I HEREBYAUTHORIZE DR. KEVIN EASLEY TO RELEASE MY MEDICAL INFORMATION TO MY PHYSICIANS AND/OR DENTIST FOR THE PURPOSE OF MEDICAL TREATMENT.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

THIS SIGNATURE SERVES AS AN AUTHORIZATION TO RELEASE MY MEDICAL RECORDS TO THE NAMED PERSON.