Please fill out this form as accurately and honestly as possible. In our practice, we are very interested in our patients' overall health. Managing the health problems caused by sleep and breathing disorders is an important part of the care we provide for you.

PATIENT INFORMATION:

Name: ______________________________ Date: ______________

1. Do you snore loudly or have been told that you snore? ☐ Yes ☐ No
2. Do you ever awaken with a sensation of gasping or choking? ☐ Yes ☐ No
3. Has anyone ever noticed that you stop breathing during your sleep? ☐ Yes ☐ No
4. Do you often wake up with a dry mouth? ☐ Yes ☐ No
5. Do you find your sleep to be non-refreshing? ☐ Yes ☐ No
6. Do you often feel tired, fatigued, or sleep during the daytime? ☐ Yes ☐ No
7. Do you ever fall asleep or nod off in situations where did not intend to? ☐ Yes ☐ No
8. Do you have (or are being treated for) high blood pressure and/or diabetes? ☐ Yes ☐ No
9. Does your bed partner have any of these symptoms? ☐ Yes ☐ No

If you answered **YES** to **3 or more questions**, you may be a candidate for a Home Sleep Test to evaluate for the presence of Obstructive Sleep Apnea.

Most medical insurance policies cover oral appliances to treat sleep apnea

Medical Doctor's Name: ______________________________

Clinic Name: ______________________________

Medical Insurance Information: ______________________________

Signature: ______________________________

In office use only

Dental Findings:
☐ Evidence of Bruxism ☐ Scalloping of Tongue ☐ Crowded Airway
☐ Tori or Bone Loss ☐ Anterior Wear ☐ Retrognathic/Class II