PATIENT INFORMATION

Email:_____

Date:_____

Patient Name:_____ Home#:_____ Cell#:_____

Home Address:_____ City:_____ State:_____ Zip:_____

SS#____-___-_____ Date of Birth:_____

Employer:_____ Work Address:_____ Work #_____

Spouse/Domestic Partner:_____ SS#_____-____-_____

Employer:_____ Work Address:_____ Work #_____

Whom may we thank for referring you to our office?_____

In case of emergency, who should we notify?_____ Phone #_____

Insurance Information

Primary Insurance Co Name:_____ Group #_____

Subscriber:_____ ID/SS#_____ Date of Birth:_____

Secondary Insurance Co Name:_____ Group #_____

Subscriber:_____ ID/SS#_____ Date of Birth:_____

To avoid misunderstandings regarding dental insurance, please be aware that ALL PROFESSIONAL SERVICES RENDERED are CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our service on the basis that insurance companies will pay our fees.

Dental Health History

Name of your previous dentist?_____ Phone#_____

Has your dental care been: ☐Regular (semi-annual) ☐ Intermittent (when necessary) ☐ When in pain

Do you feel apprehensive about visiting our office? Y/N Approximate date of your last cleaning?_____

Are you dissatisfied with the appearance of your teeth?_____

Have you ever experienced the following?:

☐ bleeding gums	☐ pus around the teeth	☐ foul odor
☐ swelling of gums	☐ loose teeth	☐ bad breath/taste
☐ pain/soreness in gums	☐ food packing between teeth	☐ spaces between teeth
☐ receding gums	☐ drifting teeth	☐ high or rough fillings

Is there sensitivity in your teeth? Y/N ☐ Hot ☐Cold ☐Sweet ☐Biting ☐ Brushing ☐ Pressure

Have you ever had an injury to your face, neck, or jaws?_____

Do you suffer from pain in your face, neck or jaws?_____

Any additional notes:_____

_____

_____

_____

EMIGH DENTAL CARE

5500 Atherton Street, Suite 430

Long Beach, CA 90815

562-493-2401

www.dremigh.com

COSMETIC * GENERAL * IMPLANTS * HYGIENE * INVISALIGN

HEALTH HISTORY

Patient Name:_____ Date:_____

CIRCLE THE APPROPRIATE ANSWER (LEAVE BLANK IF YOU DO NOT UNDERSTAND THE QUESTION)

YES NO Is your general health good?
YES NO Has there been any change in your health within the last year?
YES NO Have you been hospitalized or had a serious illness in the last three years?
If YES, why?_____
YES NO Are you being treating by a physician now? For what?_____
Date of last exam:_____ Date of last dental exam:_____
YES NO Have you had problem with your prior dental treatment?
YES NO Are you in pain/discomfort now?

HAVE YOU EXPERIENCED:

YES	NO	Chest pain (angina)?	YES	NO	Headaches?
YES	NO	Swollen ankles?	YES	NO	Fainting Spells?
YES	NO	Recent weight loss, fever, night sweats?	YES	NO	Blurred Vision?
YES	NO	Persistent cough, coughing up blood?	YES	NO	Seizures?
YES	NO	Bleeding problems, bruising easily?	YES	NO	Excessive Thirst?
YES	NO	Diarrhea, constipation, blood in stools?	YES	NO	Frequent Urination?
YES	NO	Frequent vomit, nausea?	YES	NO	Dry Mouth?
YES	NO	Difficulty urinating, blood in urine?	YES	NO	Jaundice?
YES	NO	Shortness of breath?	YES	NO	Joint pain, stiffness?
YES	NO	Waking up suddenly gasping, short of breath, heart racing?	YES	NO	Dizziness?
YES	NO	Snoring, or told you snore?	YES	NO	Ringing in ears?
YES	NO	Stopping breathing while you sleep or been told?	YES	NO	Sinus Problems?
YES	NO	Excessive daytime sleepiness?	YES	NO	Difficulty swallowing?

DO YOU HAVE OR HAVE YOU HAD:

YES	NO	Heart disease?	YES	NO	HIV?
YES	NO	Heart attack, heart defects?	YES	NO	Tumors, cancer?
YES	NO	Heart murmurs?	YES	NO	Arthritis, rheumatism?
YES	NO	Rheumatic fever?	YES	NO	Eye disease?
YES	NO	Stroke, hardening of arteries?	YES	NO	Skin disease?
YES	NO	High Blood Pressure?	YES	NO	Anemia?
YES	NO	Sleep apnea?	YES	NO	VD (syphilis or gonorrhea)?
YES	NO	Asthma, TB, emphysema, other lung disease?	YES	NO	Herpes?
YES	NO	Hepatitis, other liver disease? What type?_____	YES	NO	Kidney, bladder disease?
YES	NO	Stomach problems, ulcers?	YES	NO	Thyroid, adrenal disease?
YES	NO	Allergies to drugs, foods, or latex?_____	YES	NO	Diabetes?
YES	NO	Family history of diabetes, heart problems, tumors?	YES	NO	Hospitalizations?
YES	NO	Psychiatric care?	YES	NO	Blood transfusions?
YES	NO	Radiation treatment?	YES	NO	Surgeries?
YES	NO	Chemotherapy?	YES	NO	Pacemaker?
YES	NO	Prosthetic heart valve?	YES	NO	Contact lenses?
YES	NO	Artificial joint?	YES	NO	Any other diseases NOT listed?
			YES	NO	HPV?

ARE YOU TAKING:

YES	NO	Alcohol?	YES	NO	Tobacco in any form?
YES	NO	Drugs, medication, Over the counter medicines (including Aspirin) or natural remedies?	YES	NO	Redux/Fenfin Now or previously?

Please list:

YES	NO	Are you or could you be pregnant?	YES	NO	Taking birth control pills?
YES	NO	**Do you require a pre-medication before dental treatment?**			

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature:_____ Date:_____

Doctor Signature:_____ Date:_____

Date:_____ Changes:_____ Pt Signature:_____ Dr. Signature_____

Date:_____ Changes:_____ Pt Signature:_____ Dr. Signature_____

Sleep Health Questionnaire

Patient Name ☐ M ☐ F Gender / / DOB

Address, City, State Zip

Cell Phone Alt. Phone Email

Medical Insurance Company ID# Group#

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Patient Sleepiness Scale (Risk Factors): *Please check all that apply.*		pt.	*Additional comments below:*
1. I have been told I stop breathing while asleep	☐	8	
2. I have fallen asleep or nodded off while driving	☐	6	
3. I've woken up with shortness of breath / gasping or my heart racing	☐	6	
4. I feel excessively sleepy or fatigued during the day	☐	4	
5. I snore or have been told that I snore	☐	4	
6. I have had weight gain and found it difficult to lose	☐	4	
7. I have been diagnosed with high blood pressure	☐	4	
8. It takes me less than 10 minutes to fall asleep	☐	4	
9. I wake up more than 1 time per night	☐	4	
10. I wake up with headaches	☐	4	

Total points from above _____ .Check your Risk Level Score: ☐ **Low:** *0-7* ☐ Moderate: *8-11* ☐ High: *12-15* ☐ **Severe:** *16+*

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FOR PATIENT USE

Patient Health History (Signs & Symptoms): *Please check all that apply.*

- ☐ Snoring
- ☐ Depression/Anxiety
- ☐ Unrefreshed Upon Waking
- ☐ Witnessed Choking/Gasping/Apnea
- ☐ Irritability/Moodiness
- ☐ Wakes Up with Dry Mouth
- ☐ Sinus/Allergy Issues
- ☐ Grind Teeth
- ☐ Diabetes
- ☐ History of Stroke/Heart Disease
- ☐ Acid Reflux/GERD
- ☐ Hypertension
- ☐ Memory Loss
- ☐ Family History of OSA/Snoring
- ☐ Deviated Septum
- ☐ Currently Not Using Prescribed CPAP

I authorize this practice to release any medical information for the purpose of the coordination of care.

Patient Signature **Date**

Ask your dentist to complete.

- ☐ BMI > 30 (see reverse)
- ☐ Narrow upper arch
- ☐ Visual airway obstruction
- ☐ Large/scalloped tongue
- ☐ Neck size: Male ≥ 17" or Female ≥ 16"

' "

Height lbs Weight

inches Neck Size Blood Pressure

BPM Heart Rate BMI

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Prescription / Statement of Medical Necessity

*Certain insurance payers require a minimum **Risk Level Score of High** and/or **at least two (2) Signs & Symptoms**; sometimes up to four (4).*

Home sleep study (*G47.33 to be used to rule out OSA, unless stated differently. If other, please specify*): _____

- ☐ **Baseline 2-Night or (_____-Night) home sleep study**
- ☐ **Assessment of oral appliance efficacy**

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

Emigh Dental Care
Dr. Todd Emigh
5500 Atherton Street, Suite 430,
Long Beach, CA 90815
NPI#: 1093093890
Office Contact: Crystal
Phone: (562) 493-2401
emighdentalcare@gmail.com

AS

Dr. Signature State Lic#: 60598 **Date** Account Code

FOR OFFICE USE

EzSLEEP™ In-Home Testing

Fax: 888-793-3903 • OrderEntry@EzSleepTest.com • Phone: 888-240-7735

Fax or email completed form with copies of ID & medical insurance cards