Osborn™
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Craniofacial Sleep Medicine

PATIENT INFORMATION FORM

Date:_____

First Name _____Middle Initial: ____ Last Name: _____

Sex: ☐Male ☐ Female Date of Birth: _____ Age: _____ Social Security #: _____

Street: _____

City: _____ State_____ Zip_____

Home: (_____) _____ Cell: (_____) _____

Email: _____

Employer: _____ Work#: _____

Previous Dentist: _____ Dentist Tel.: (_____) _____

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ Minor

Employed: ☐Full Time ☐Part Time ☐Retired ☐Unemployed

Referred by or how did you hear about us: _____

Dental Concerns: _____

Sleep/Breathing Concerns: _____

PRIMARY INSURANCE COMPANY

Primary Insurance: _____ Phone: _____

Policy #: _____Group #: _____

Patient relation to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy Holder Name: _____

Date of Birth: _____ Social Security: _____

Signature: _____ Date: _____

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www.osborndds.com

9105 Kimmer Drive
Lone Tree, CO 80124
303-799-9993

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New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth____/____/____

Chief Complaint: _____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

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SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____# of cups of tea per day

_____ # cans or glasses of soda per day _____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol: ❑ None ❑ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

Tobacco: ❑ None ❑ Yes _____ # of cigarette packs per day _____ # of years

Recreational Drugs (such as marijuana or cocaine): ❑ None ❑ Yes

If yes, which ones? _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Children: ❑ No ❑ Yes How many? _____

Pets: ❑ No ❑ Yes How many? _____ What type of pet? _____

Do you have any children or pets that sleep in your bedroom? ❑ No ❑ Yes _____

HEALTH HISTORY

Do you have a health history of any of the following medical illnesses? (Check if "yes" to all that apply):

❑ High blood pressure/hypertension ❑ Diabetes ❑ Chronic insomnia

❑ Heart disease ❑ Overweight/obesity ❑ Restless legs syndrome

❑ Stroke ❑ Snoring ❑ Multiple sclerosis

❑ Congestive heart failure ❑ Sleep apnea ❑ Sleep walking

❑ Depression ❑ Anxiety

Other Health Conditions Not Listed:

_____

_____

_____

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REVIEW OF SYMPTOMS

Respiratory:

Cough: ❑ Yes ❑ No

Asthma: ❑ Yes ❑ No

Wheezing: ❑ Yes ❑ No

Poor Exercise Tolerance: ❑ Yes ❑ No

Genitourinary:

Bed Wetting: ❑ Yes ❑ No

Frequent Urination: ❑ Yes ❑ No

Difficulty Urinating: ❑ Yes ❑ No

Blood in Urine: ❑ Yes ❑ No

Erectile dysfunction ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss: ❑ Yes ❑ No

Constitutional:

Loss of Appetite: ❑ Yes ❑ No

Sweats: ❑ Yes ❑ No

Fever: ❑ Yes ❑ No

Fatigue: ❑ Yes ❑ No

Weight Gain: ❑ Yes ❑ No

Weight Loss: ❑ Yes ❑ No

Gastrointestinal:

GERD/Heartburn/Indigestion: ❑ Yes ❑ No

Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No

Nausea/Vomiting: ❑ Yes ❑ No

Abdominal Pain: ❑ Yes ❑ No

Jaundice: ❑ Yes ❑ NO

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No

Muscle Pain: ❑ Yes ❑ No

Red or Swollen Joints: ❑ Yes ❑ No

Temporomandibular Joint

(TMJ) pain/jaw discomfort: ❑ Yes ❑No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

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Neurologic:

Weakness: ❑ Yes ❑ No

Seizures: ❑ Yes ❑ No

Involuntary Tongue Biting: ❑ Yes ❑ No

Passing Out: ❑ Yes ❑ No

Dizziness: ❑ Yes ❑ No

Headaches: ❑ Yes ❑ No

Numbness: ❑ Yes ❑ No

Restless Leg Syndrome: ❑ Yes ❑ No

Psych:

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Difficulty with Focus: ❑ Yes ❑ No

Trouble Concentrating: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

Skin:

Unusual Moles : ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

Cardiac:

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Allergy/Immunology:

Sneezing: ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Hives: ❑ Yes ❑ No

Itchy Eyes or Nose: ❑ Yes ❑ No

Nasal allergies/Hay fever: ❑ Yes ❑ No

Nasal Congestion: ❑ Yes ❑ No

Endocrine:

Heat Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Cold Hands/Feet: ❑ Yes ❑ No

Decreased Libido: ❑ Yes ❑ No

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Financial and Appointment Cancellation Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read our financial policy carefully and if you have any questions, please don't hesitate to ask a member of our staff.

Financial Policy

One important aspect of optimal patient care is to have an agreement as to financial responsibility to avoid any misunderstandings and to ensure timely payment for services. Osborn Advanced Dentistry & Craniofacial Sleep Medicine policy requires that all patients sign the Authorization and Consent for Treatment Form prior to receiving dental services. The form confirms that patients understand services being provided are necessary and appropriate. The form also advises patients of their complete financial responsibility for all services received without regard to insurance eligibility or coverage determinations. Patients are ultimately responsible for all charges for services rendered. Payment is expected at the time of service for all charges owed for the current visit as well as any prior balance. Osborn Advanced Dentistry & Craniofacial Sleep Medicine will bill your dental insurance as a courtesy for possible reimbursement. There are occasions where diagnosis of treatment may change and therefore; cost may also be affected.

I understand that Osborn advanced Dentistry & Craniofacial Sleep Medicine is relying on the insurance benefit detail that my insurance company and I have provided and is not responsible for any discrepancies in the estimated insurance coverage. Patient is responsible for all amounts not covered by insurance. I authorize Osborn Advanced Dentistry & Craniofacial Sleep Medicine to release any information about my dental care to my dental insurance which includes dental records, diagnostics and treatment.

Appointment Cancellation Policy

At Osborn Advanced Dentistry & Craniofacial Sleep Medicine we value the time we have set aside to see and treat you. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 48-hour notice. If you are more than 10 minutes late to an appointment, we may need to reschedule due to the length of time exclusively scheduled for you. No shows and last minute cancellations will be a fee of $50 and will be paid before next scheduled appointment.

I have read and understand Osborn Advanced Dentistry & Craniofacial Sleep Medicine's Financial and Appointment Cancellation Policy and agree to comply.

Signature: _____ Date: _____

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Consent for Internet Communications

I grant permission for Osborn Advanced Dentistry & Craniofacial Sleep Medicine to upload and store confidential information (including account, appointments and clinical information) to their secured database. I understand that, for security purposes, this site requires a user ID and password for access and usage and that information is only available to Dr. Angela Osborn and employees of this practice.

I also grant permission to receive emails, text messages and/or voicemails to remind me and confirm upcoming appointments. I understand that it is my responsibility to ensure that this practice is kept informed of any changes made to my email address, home phone or mobile phone needed for this communication to help ensure proper delivery and confidentiality.

I also understand that State and Federal laws as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand that this practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance and storage of my information and use their best efforts to cause all persons or entities under their direction or control to comply with such laws.

I agree that this practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services and is acting on my behalf in uploading my patient information. I understand that this practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the database on my behalf.

I understand Osborn Advanced Dentistry & Craniofacial Sleep medicine **CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OF THE SERVICES.**

I have read the information above and consent to these guidelines.

Signature_____ Date _____

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General Consent

Thank you, for choosing Osborn Advanced Dentistry for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction**. Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia)**. Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, muscle permanent numbness.
3. **Muscle or joint tenderness**. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding**.
5. **Swallowing or inhaling small objects**.

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedure that are recommended to you.

I have read and understand the statement on this page:

Patient's NAME Printed _____Date _____

Patient's Signature _____ Date _____

Guardian's Signature (if a minor) _____Date _____

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Patient Introduction to Laser Bacterial Reduction Consent

We are constantly learning and striving to advance the standard of patient care in our office. As such we have recently added a new procedure to your routine cleaning care to help fight periodontal disease.

Periodontal disease affects approximately 80% of adults and is growing epidemic in our society. Understanding of this disease has increased greatly over the last few years. We now know that Periodontal Disease is a bacterial infection in the pockets around teeth. As such, we now not only treat perio with removal of mechanical irritants and diseased tissue (your normal cleaning) but are also addressing the underlying infection that causes it. With that thought in mind we recommend that all of our patient have their teeth decontaminated prior to cleaning appointments for three major reasons.

1. **To reduce or eliminate bacteremias**. During the normal cleaning process most patients will have some areas that may bleed, this allows bacteria that are present in all our mouths to flood into the bloodstream and sometimes settle in weakened areas of our body, such as a damaged heart valve or artificial knee or hip etc. We pre-medicate those patients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these oral pathogens have now been linked to a number of other diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes, etc. Needless to say anything that we can do to reduce or eliminate these bacteremias is a positive for our patients.
2. **To prevent cross contamination of infections in one area of your mouth to other areas**. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to others.
3. **To kill periodontal disease bacteria** and stop their infections before they cause physical destruction to loss of attachment around your teeth.

The laser decontamination process is painless and normally takes about 5-10 minutes. We highly recommend that you take advantage of this service as part of your routine and periodontal maintenance appointment. **Laser decontamination is $42 and is NOT covered by insurance. Unfortunately, insurance coverage is almost always behind the leading edge in high tech health care.**

Please ask our hygienist if you have any questions regarding this treatment. Please sign below if it's ok to perform this service for you on ALL your future hygiene appointments.

Patient name (print) _____

Sign _____Date_____

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$

EPWORTH SLEEPINESS SCALE

Name_____DOB_____

Date _____Gender_____

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

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 - Would **never** doze

1 - **Slight** chance of dozing

2 - **Moderate** chance of dozing

3 - **High** chance of dozing

*****It is important that you answer each question as best as you can.*****

Situation	**Chance of dozing** (out of 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. a theatre 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	
Total out of 24	

Score Interpretation:
(1-10) Normal Range (10–16) Excessively sleepy (16-24) Abnormally sleepy