Intake Form

DAG
DOCTOR ALLIANCE GROUP

Welcome,

Our office screens all new patients for potential air flow disorders prior to any dental treatment. We also screen all existing patients periodically throughout the year. Please complete this form and return it to the front desk staff.

Patient Name: First _____ Last _____ **Gender:** Male Female

Patient Health History: Please check all that apply

	Type 2 diabetes		History of stroke
	Heavy snoring		Difficulty concentrating
	High cholesterol		Heart disease
	Restless sleep		Morning headaches
	Daytime sleepiness		High blood pressure
	Periodically stop breathing during sleep		Headaches/migraines
	COPD		Clench or grind your teeth
	Experience pain (head, jaw, neck, shoulder(s), arm(s), low back)		Been in car accident over 8 mph or any trauma (sports, injury, fall) in the last year
	History of smoking		Asthma
	Have CPAP – I don't use it		Have CPAP – I use it

Below are 8 questions regarding sleepiness. Please circle only one answer per question. **Answer these questions as if it is your day off, you've had no stimulants, including caffeine, and you have the opportunity to relax.**

How Likely Are You To Fall Asleep While...	Never	Slight	Moderate	High
1) Sitting and reading?	0	1	2	3
2) Watching TV?	0	1	2	3
3) Sitting inactive in a public place (meeting, theater, etc.)?	0	1	2	3
4) As a passenger in a car for an hour without a break?	0	1	2	3
5) Lying down to rest in the afternoon when circumstances permit?	0	1	2	3
6) Sitting and talking to someone?	0	1	2	3
7) Sitting quietly after lunch without alcohol?	0	1	2	3
8) In a car while stopped for a few minutes in traffic?	0	1	2	3

Score Summary: _____

Patient Information: Please fill out the sections below. Those with asterisks (*) are required.

*Date of birth _____ *Height _____ *Weight _____

*Address _____ *City _____ *State _____ *ZIP _____

SSN # _____ E-mail address _____

Phone numbers: Home _____ Cell _____ *Best #_____

Neck circumference (office can measure if you are unsure) _____

Patient Signature:

_____

Signature (if under 18 years of age, guardian signature needed) Date

_____ I have read/reviewed and agree to the HIPAA information on the opposite side of this page. Please initial upon completion.