Mid-Michigan
Dental Sleep Center

Registration

Patients Name: _____ Date of Birth: _____Date of Appt:_____

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

Cell Phone: _____ Work phone: _____Sex: M □ F □ SSN:_____

Emergency Contact and phone #: _____

Occupation: _____ Employer:_____

Medical Insurance Company:_____ Subscriber #: _____

Name of Subscriber, relationship: _____ Birthdate: _____

Secondary Medical Insurance: _____ Subscriber:_____

How did you hear about us?_____

Sleep Doctor: _____ Location and Phone #:_____

Primary Care Dr: _____ Location and Phone #: _____

General Dentist: _____ Location and Phone #: _____

Date of last medical exam: _____ Date of last Dental Exam: _____

Have you been diagnosed or treated for a sleep disorder? Yes □ No □ When? _____

Most recent sleep study date: _____

Have you used CPAP? Yes □ No □ How long? _____ Pressure level:_____

How often do you use CPAP? _____ If any, reason for stopping: _____

Have you been evaluated by an Ear Nose and Throat Dr (ENT)? Yes □ No □

Have you had any throat or nose surgery? Yes □ No □

Have any immediate family members been diagnosed or treated for a sleep disorder? Yes □ No □

Present body weight: _____ lbs Height: _____

Are you taking any medications? (Please provide a list) _____

_____

Are you allergic to or have you had any reactions to the following (circle which):

Acrylics Metals (nickel, mercury, etc) Latex rubber Other:_____

601 S Grand Ave., Lansing, MI 48933
Tel: 517-485-1900
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Fax: 517-485-0324

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Sleep, Snoring and Apnea History

Is there a family history of snoring? Yes ☐ No ☐

Do you become easily fatigued? Yes ☐ No ☐ What time of day?_____

Do you dream? Yes ☐ No ☐ How often? _____

Do you have trouble falling or staying asleep? Yes ☐ No ☐ Which one?_____

Do you snore or have you been told that you do? Yes ☐ No ☐

Do you wake up with headaches? Yes ☐ No ☐

Have you had chronic sleepiness, fatigue or weariness you cannot explain? Yes ☐ No ☐

Do you often fall asleep watching TV or reading? Yes ☐ No ☐

Have you fallen asleep during the day against your will? Yes ☐ No ☐

Have you had to pull off the road while driving due to sleepiness? Yes ☐ No ☐

Have you been more irritable or short-tempered? Yes ☐ No ☐

Have you felt your memory and/or intellect is impaired? Yes ☐ No ☐

Have you been told that you stop breathing while asleep? Yes ☐ No ☐

About how many times per night do you wake up? _____

What time do you normally go to bed? _____ Get up in the morning? _____

Of the hours in bed, how many are you asleep? _____

Would you rate the quality of your sleep: Good ☐ Fair ☐ Poor ☐

Do you have difficulty breathing through your nose? Yes ☐ No ☐

TMJ History

Do you have chronic headaches? Yes ☐ No ☐ Do you have chronic neck pain? Yes ☐ No ☐

Does your jaw pop, click or make noise? Yes ☐ No ☐ Pain or ringing in your ears? Yes ☐ No ☐

Jaw muscles feel tired, stiff or painful? Yes ☐ No ☐ Do you clench during the day? Yes ☐ No ☐

Do you grind your teeth at night? Yes ☐ No ☐ Trouble opening your mouth widely? Yes ☐ No ☐

Does your jaw lock open or closed? Yes ☐ No ☐ Sought care for TMJ issues? Yes ☐ No ☐

Do you feel your bite is different, unstable or uncomfortable? Yes ☐ No ☐

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Medical History

Are you currently under medical treatment? Yes □ No □

Do you use tobacco products? Yes □ No □

Do you use controlled substances? Yes □ No □

Are you pregnant or think you may be pregnant? Yes □ No □

Do you have or have you ever had any of the following:

Heart Disease	**Y N**	High Blood Pressure	**Y N**	Chest Pains	**Y N**
Heart Attack	**Y N**	Cardiac Pacemaker	**Y N**	Easily Winded	**Y N**
Rheumatic Fever	**Y N**	Heart Murmor	**Y N**	Stroke	**Y N**
Swollen Ankles	**Y N**	Mitral Valve Prolapse	**Y N**	Hay Fever/Allergies	**Y N**
Fainting / Seizures	**Y N**	Frequently Tired	**Y N**	Tuberculosis	**Y N**
Asthma	**Y N**	Anemia	**Y N**	Radiation Therapy	**Y N**
Low Blood Pressure	**Y N**	Emphysema	**Y N**	Glaucoma	**Y N**
Cancer	**Y N**	Epilepsy/Convulsions	**Y N**	Recent Weight Loss / Gain	**Y N**
Leukemia	**Y N**	Arthritis	**Y N**	Liver Disease	**Y N**
Diabetes	**Y N**	Heart Trouble	**Y N**	Breathing Problems	**Y N**
Angina	**Y N**	Frequent Headaches	**Y N**	Kidney Disease	**Y N**
Hepatitis / Jaundice	**Y N**	Thyroid Problems	**Y N**	Acid Reflux	**Y N**
Depression	**Y N**	Mental Illness	**Y N** (Diagnosis:_____)		

Dental History

Do your gums bleed while brushing or flossing? **Y N**

Have you ever been diagnosed or treated for gum disease? **Y N**

Do you feel any pain in any of your teeth? **Y N**

Have you had any head, neck or jaw injuries? **Y N**

Have you had orthodontic treatment? Y N

Do you wear dentures or partial dentures? Y N

Are you aware of any needed dental work? Y N

Date of last Dental Cleaning: _____

I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered. I understand that providing inaccurate answers to my medical history can be dangerous to my health. I authorize Mid-Michigan Dental Sleep Center to release any information to third party payers or health practitioners. I understand that my medical insurance may not pay for any of my treatment and I agree to be responsible for payment of all services rendered on my behalf. I understand that co-pays are my contractual responsibility and payable at the time of my visit.

Patient Signature:_____ Date: _____

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