CHARLES A. DORING, D.D.S., F.A.G.D.
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ROBERT B. TILKIN, D.D.S., M.S., F.A.G.D.

Snoring/Sleep Apnea Registration Form

Name_______________________________________

Employer___________________________________
Medical Insurance Carrier___________________________
Subscriber Number_________________________
Name of Subscriber_________________________
Date of Birth (Subscriber)____________________
Relationship to Subscriber___________________
Who is responsible for this account?_________________

Referred By__________________________________
Sleep Physician's Name___________________________
Office Address_____________________________
Office telephone___________________________
Primary Care Physician___________________________
Office Address_____________________________
Office telephone___________________________
General Dentist_________________________________
Office Address_____________________________
Office Telephone___________________________
Date of last examination_____________________
Have you ever had braces? Yes____ No____

Have you had an overnight sleep study? Yes____ No____ Date____
Do you snore? Yes____ No____ Don't Know____
Have you used CPAP? Yes____ No____ How long?___________
Pressure Level of CPAP_______
If any, the reason for stopping CPAP________________
Height________ Weight__________ Neck Size ______________
Have you gained weight in the past year? Yes____ No____
If so, then how much?_______________
Have you had an evaluation by an ENT? Yes____ No____
Have you had any throat or nose surgery? Yes____ No____
Do you have daytime sleepiness? Yes____ No____
Is there a family history of snoring? Yes____ No____
How often do you awaken at night? ______________

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