Michael Tong, D.D.S
Exclusively Treating Sleep Apnea, Snoring, and CPAP Intolerance
We Treat the Tough Cases

	DATE

SLEEP SCREENING QUESTIONNAIRE

Please answer each question accurately and to the best of your knowledge, to help us obtain an accurate picture of your health and sleep issues, only this way will we be able to provide you with the best treatment solution.

FIRST NAME	**MIDDLE**	**LAST NAME**
BIRTH DATE	**GENDER** ☐ MALE ☐FEMALE	**SS#**
ADDRESS		**EMAIL**
CITY / STATE / ZIP		
CELL PHONE	**HOME PHONE**	**WORK PHONE**

FAMILY PHYSICIAN	**FAMILY DENTIST**
PHONE NUMBER	**PHONE NUMBER**
CITY	**CITY**
PLEASE LIST ALL OTHER HEALTHCARE PROVIDERS SEEN IN THE LAST 9 MONTHS	
REFERRED BY	**EMPLOYED BY**
	ADDRESS

WHAT ARE THE MAIN COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
PLEASE **CHECK OFF** YOUR COMPLAINTS

___ I HAVE BEEN TOLD THAT I "STOP BREATHING" WHEN SLEEPING
___ FEELING UN-REFRESHED IN THE MORNING
___ SIGNIFICANT DAYTIME DROWSINESS
___ DIFFICULTY FALLING ASLEEP
___ FREQUENT HEAVY SNORING
☐ AFFECTS OTHERS?
___ OTHER COMPLAINTS: _____

___ NIGHTTIME CHOKING SPELLS
___ MORNING HOARSENESS
___ MORNING HEADACHES
___ TEETH GRINDING
___ JAW CLICKING
___ JAW PAIN

I understand that I am not being treated by the doctors at Snore Experts for any dental diseases or conditions of the mouth. I am only seeking treatment for Snoring and/or Sleep Apnea. I see a regular dentist for all my dental care. I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

PATIENT SIGNATURE	**DATE**

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www.SnoreExperts.com
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HEALTH HISTORY

FIRST NAME	LAST NAME	DOB

HAVE YOU EVER HAD AN OVERNIGHT SLEEP TEST? ☐ YES ☐ NO	**NAME & LOCATION**
IF YES, WHO WAS ORDERING PHYSICIAN?	**DATE OF TEST**
ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO	**DO YOU TAKE MEDICATIONS FOR THE FOLLOWING?** ☐BLOOD PRESSURE ☐ANXIETY ☐ANTI-DEPRESSANTS ☐SLEEPING PILLS
LIST ANY OTHER ALLERGIES:	**LIST ANY OTHER MEDICATIONS:**
DO YOU WEAR DENTURES? ☐ YES ☐ NO	

FAMILY HISTORY

HAVE ANY BLOOD RELATIVES BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING?

☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ MOOD DISORDER ☐ SLEEP DISORDER

SOCIAL HISTORY

ALCOHOL CONSUMPTION: HOW OFTEN DO YOU CONSUME ALCOHOL WITHIN 2-3 HOURS OF BEDTIME?

☐ NEVER ☐ OCCASIONALLY ☐ 1-2X/WK ☐ 2-3X/WK ☐ DAILY

SEDATIVE CONSUMPTION: HOW OFTEN DO YOU TAKE SEDATIVES WITHIN 2-3 HOURS OF BEDTIME?

☐ NEVER ☐ OCCASIONALLY ☐ 1-2X/WK ☐ 2-3X/WK ☐ DAILY

CAFFEINE CONSUMPTION: HOW OFTEN DO YOU CONSUME CAFFEINE WITHIN 2-3 HOURS OF BEDTIME?

☐ NEVER ☐ OCCASIONALLY ☐ 1-2X/WK ☐ 2-3X/WK ☐ DAILY

MEDICAL HISTORY

MARK ONE IN EACH ROW	YES	NO		YES	NO		YES	NO
DIABETES I II	☐	☐	HEART DISEASE	☐	☐	BLOOD TRANSFUSION	☐	☐
HIGH BLOOD PRESSURE	☐	☐	ANGINA	☐	☐	HEMOPHILIA	☐	☐
LOW BLOOD PRESSURE	☐	☐	ARTERIOSCLEROSIS	☐	☐	AIDS OR HIV	☐	☐
MOOD DISORDER	☐	☐	CONGESTIVE HEART FAILURE	☐	☐	ARTHRITIS	☐	☐
LIVER DISEASE	☐	☐	DAMAGED HEART VALVES	☐	☐	AUTOIMMUNE DISEASE	☐	☐
EPILEPSY	☐	☐	HEART ATTACK	☐	☐	RHEUMATOID ARTHRITIS	☐	☐
NEUROLOGICAL DISORDERS	☐	☐	HEART MURMUR	☐	☐	LUPUS	☐	☐
INSOMNIA	☐	☐	THYROID PROBLEMS	☐	☐	ASTHMA	☐	☐
FATIGUE	☐	☐	ACID REFLUX / HEARTBURN	☐	☐	BRONCHITIS	☐	☐
BRAIN FOG	☐	☐	CONGENITAL HEART DEFECT	☐	☐	EMPHYSEMA	☐	☐
MENTAL HEALTH DISORDER	☐	☐	MITRAL VALVE PROLAPSE	☐	☐	SINUS TROUBLE	☐	☐
MEMORY LOSS	☐	☐	PACEMAKER	☐	☐	TUBERCULOSIS	☐	☐
HEADACHES/MIGRAINES	☐	☐	RHEUMATIC FEVER	☐	☐	CANCER	☐	☐
DIFFICULTY CONCENTRATING	☐	☐	STROKE	☐	☐	CHRONIC PAIN	☐	☐
UNEXPLAINED WEIGHT LOSS	☐	☐	ABNORMAL BLEEDING	☐	☐	EXCESSIVE URINATION	☐	☐
UNEXPLAINED WEIGHT GAIN	☐	☐	ANEMIA	☐	☐	KIDNEY DISEASE	☐	☐
OTHER: _____	☐	☐	OTHER: _____	☐	☐	OTHER: _____	☐	☐

HOW OFTEN DO YOU FEEL TIRED OR FATIGUED AFTER YOUR SLEEP?

☐ NEARLY EVERY DAY ☐ 1-2X/WEEK ☐ 1-2/MONTH ☐ NEVER OR NEARLY NEVER

DO YOU HAVE DAILY PROBLEMS WITH SHORT TERM MEMORY, BRAIN FOG, OR DIFFICULTY WITH NAMES?

☐ NEARLY EVERY DAY ☐ 1-2X/WEEK ☐ 1-2/MONTH ☐ NEVER OR NEARLY NEVER

DO YOU HAVE TROUBLE FINDING THE CORRECT WORD OR REPEAT THE SAME THING OVER AND OVER?

☐ NEARLY EVERY DAY ☐ 1-2X/WEEK ☐ 1-2/MONTH ☐ NEVER OR NEARLY NEVER

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WATERMARK MEDICAL ARES QUESTIONNAIRE

Last	First	Middle Initial
Date of Birth	○Male ○Female	Dr.
Height _____feet _____inches	Weight _____pounds	Neck Size_____inches

MEDICAL CONDITIONS: Have you been diagnosed or treated for any of the following conditions?

High Blood Pressure	○ Yes	○ No	Stroke	○ Yes	○ No
Heart Disease	○ Yes	○ No	Depression	○ Yes	○ No
Diabetes	○ Yes	○ No	Sleep Apnea	○ Yes	○ No
Lung Disease	○ Yes	○ No	Nasal oxygen use	○ Yes	○ No
Insomnia	○ Yes	○ No	Restless legs syndrome	○ Yes	○ No
Narcolepsy	○ Yes	○ No	Morning headaches	○ Yes	○ No
Sleep Medication	○ Yes	○ No	Pain Medication	○ Yes	○ No

EPWROTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropiate box for each situation. (M.W.Johns, Sleep 1991)

0=would never doze/ 1=sleight chance of dozing/ 2=moderate change of dozing/ 3= high change of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitiing, inactive, in a public place (theater, meeting, etc.)	0	1	2	3
As a passanger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 times/wk	Always 5-7 times/wk
On average in the past month, how often have you snored or been told that you snore?	○ +0	○ +1	○ +2	○ +3	○ +4
Do you wake up choking or gasping?	○ +0	○ +1	○ +2	○ +3	○ +4
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	○ +0	○ +1	○ +2	○ +3	○ +4
Do you have problem keeping your legs still at night or need to move them to feel comfortable?	○ +0	○ +1	○ +2	○ +3	○ +4

I have personally completed this questionnaire. By signing this agreement, you acknowledge that you have read, understand, and agree to the terms and conditions of the Patient Authorization form on the reverse side of this form.

Patient Signature_____**Date:**_____

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CPAP INTOLERANCE / NON-COMPLIANCE AFFIDAVIT

FIRST NAME	LAST NAME	DOB

☐ **It has been recommended that I use CPAP therapy to manage my diagnosed Obstructive Sleep Apnea condition and I REFUSE to do so for the following reasons:**

☐ **I have attempted to use CPAP to manage my diagnosed Obstructive Sleep Apnea condition. I find CPAP intolerable to use on a regular basis due to the following reasons:**

- ☐ CPAP NOISE DISRUPTS MY AND/OR BED PARTNERS SLEEP
- ☐ PRESSURE ON LIP CAUSES TOOTH RELATED PROBLEMS
- ☐ RESTRICTED MOVEMENTS DURING SLEEP
- ☐ CLAUSTROPHOBIC ASSOCIATIONS
- ☐ UNABLE TO SLEEP COMFORTABLY
- ☐ CPAP NOT EFFECTIVE
- ☐ LATEX ALLERGY
- ☐ AN UNCONSCIOUS NEED TO REMOVE THE CPAP AT NIGHT
- ☐ DISTURBED SLEEP CAUSED BY PRESENCE OF DEVICE
- ☐ DISCOMFORT FROM STRAPS/MASK
- ☐ MASK UNABLE TO FIT PROPERLY
- ☐ MASK LEAKS
- ☐ OTHER: _____

LIST ANY OTHER THERAPIES (LIFESTYLE CHANGES, WEIGHT LOSS ATTEMPTS, SMOKING CESSATION FOR AT LEAST ONE MONTH, SURGERIES, ETC.) YOU HAVE HAD FOR BREATHING DISORDERS:

BECAUSE OF MY INTOLERANCE/INABILITY OR REFUSAL TO USE CPAP THERAPY, I WISH TO HAVE AN ALTERNATIVE METHOD OF TREATMENT. THAT FORM OF THERAPY IS AN ORAL APPLIANCE AS PRESCRIBED BY DR. JONATHAN GREENBURG DDS, AND/OR DR. MICHAEL TONG, D.D.S

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MEDICAL RECORDS RELEASE REQUEST

PATIENT INFORMATION		
PATIENT NAME	**LAST NAME**	**DOB**

PROVIDER INFORMATION	
DOCTORS NAME	**ATTN**
ADDRESS	
CITY / STATE / ZIP	
PHONE	**FAX**

PLEASE FAX MEDICAL RECORDS TO (818) 796-3322

RECORDS REQUESTED

- ☐ **POLYSOMNOGRAM / DIAGNOSTIC SLEEP STUDY**
- ☐ **OTHER:** _____

I authorize the release of medical records, including sleep studies or copies of such, sent to:

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Toluca Lake, CA 91602

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MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Snore Experts. When you schedule an appointment with Snore Experts, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us enough time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation /No Show Policy below.

- Effective September 1st, 2022, any established patient who fails to show or cancels/reschedules an appointment and has not contacted out office with at least 24 hours' notice will be considered a No Show and charged a $75.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment within the 24 hours' notice a second time will be charged a $150.00 fee.
- If a third No Show or cancellation/reschedule with no 24-hour notice should occur, the patient may be dismissed from Snore Experts.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when the times allows, we make reminder calls for appointments. If you do not receive an appointment reminder, call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your schedule appointment. If you should experience extenuating circumstances, please contact our office, who may be able to waive the No Show fee. You may contact Snore Experts 24 hours a day, 7 days a week at the number listed below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

Snore Experts (818) 578-3500

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent / Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date