Front Range Dental Sleep Medicine

ANDREW T SMITH, DDS

SPECIALTY TRAINED DENTIST: PRACTICE RESTRICTED TO
INTRAORAL APPLIANCE THERAPY FOR SLEEP APNEA & SNORING
OROFACIAL PAIN, TEMPOROMANDIBULAR JOINT DISORDERS (TMJ) & RELATED HEADACHES

PATIENT INFORMATION

Patient's Name_____ Date_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____Work Phone_____Occupation_____

Social Security Number_____Birthdate_____Age_____

Marital Status_____ Name of spouse_____

Purpose ofVisit_____

Briefly list your chief complaints_____

Whom may we thank for referring you to this office? _____

Address: _____ Phone # _____

Emergency Contact_____ Phone #_____ Relationship_____

INSURANCE INFORMATION

Insurance Company_____ ID Number_____

Group/Policy Number_____ Insured's SSN_____

Insurance Address_____ Phone _____

Claim Number_____Adjuster/Contact_____

Insured's Birthdate_____ Insured's Name_____

HEALTH HISTORY

__Anemia __Diabetes __Epilepsy/Seizure __Bleeding Disorder __Mitral Valve Prolapse

__Heart Surgery __Artificial Heart Valves __Congenital Heart Defect __Heart Murmur

__History of Rheumatic Fever/ Endocarditis __Heart Disease __Pacemaker __High Blood Pressure

__Allergy to latex __Tuberculosis __Kidney Disease __Prosthetic Joint (knee, hip, or other joint)

__Hepatitis/Liver Disease __Infectious Disease (HIV or AIDS) __Asthma or other Breathing Disorder

__*Other: Explain*_____

__Allergy: _____

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Email: asmithsleepdds@gmail.com

Are there any other health problems of importance? _____

Are you taking any medication? __No __Yes, list the medications & the dose, both over-the-counter or prescriptions:

_____

Are there any physical conditions we need to know about? _____

For women: Are you pregnant? __No __Yes, Are you taking birth control medication? __No __Yes, Name: _____

Name of your Primary Care Physician_____Phone_____

Address_____

Please list the names of any Doctors you are currently seeing or see on a regular basis:

Name	Phone Number	Reason or condition being treated
_____	_____	_____
_____	_____	_____

LIFESTYLE AND PHYSICAL ACTIVITIES

(Please check the appropriate response)

Do you use Tobacco? __No __Yes Type: __Cigarettes __Packs per day __Cigars __Smokeless

Drink alcohol containing beverages? __No __Yes Type consumed __Beer __Wine __Liquor __Drinks per week

Engage in high risk activities (please describe):_____

Exercise: _No _Yes, Please Describe:_____

Do you have a lot of stress in your life? __No __Yes

AUTHORIZATION FOR INITIAL VISIT

I understand that the visit scheduled upon completion of this document is for an evaluation and consultation. The visit will consist of a review of my history and any reports that are available and clinical examination followed by a consultation and discussion of the findings and he recommended course of treatment/action.

Signature:_____

AUTHORIZATION TO SUBMIT INSURANCE CLAIM

I authorize Dr. Smith to submit claims on my behalf for payment of services rendered to the named insurance company on this form. Furthermore, I authorize the insurance company to pay benefits directly to Dr. Smith on my behalf. I understand that if the insurance company denies payment of the claims, or if payment is directly mailed to me, I become responsible for the payment of the services rendered by Dr. Smith. After 90 days I accept full responsibility for payment to Dr. Smith.

Signature:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Smith to release information relative to my medical history, diagnosis and treatment to the named insurance company or to any health care provider related to my treatment.

Signature:_____