SNOREEXPERTS

Jonathan Greenburg, DDS, FAGD | Jay Khorsandi DDS

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
AGE	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** _____

Corporate Office: 5400 Balboa Blvd, Suite 120, Encino, CA 91316
www.SnoreExperts.com
Phone: (818) 205-1122 Fax: (818) 796-3322
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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: _____	☐	☐

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EPWORTH SLEEPINESS SCALE

FIRST NAME	LAST NAME	DOB

How likely are you to doze off or fall asleep in the following situations?

CIRCLE ONE IN EACH ROW	NEVER	SLIGHT	MODERATE	HIGH
SITTING & READING	0	1	2	3
WATCHING TV	0	1	2	3
SITTING INACTIVE IN PUBLIC (AT THE MOVIES, IN A MEETING)	0	1	2	3
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	0	1	2	3
LYING DOWN TO REST IN THE AFTERNOON	0	1	2	3
SITTING & TALKING TO SOMEONE	0	1	2	3
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	0	1	2	3
IN A CAR, WHILE STOPPED FOR A SHORT TIME IN TRAFFIC	0	1	2	3
	FOR OFFICE USE ONLY		TOTAL	

	HEIGHT	FT	IN
	WEIGHT	LBS	
	OFFICE USE	BMI	

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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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. JAY KHORSANDI DDS.

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RECORDS RELEASE REQUEST

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

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

PLEASE FAX SLEEP STUDY TO 1 (818) 796-3322

RECORDS REQUESTED

☐ **POLYSOMNOGRAM / DIAGNOSTIC SLEEP STUDY**

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

SNORE EXPERTS
JONATHAN GREENBURG DDS FAGD
JAY KHORSANDI DDS
5400 BALBOA BLVD, STE 120
ENCINO, CA 91316

1 (818) 796-3322 – FAX

→ **PATIENT SIGNATURE**	**DATE**

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PRESCRIPTION REQUEST BY PATIENT FOR DME

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

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

PLEASE FAX RX TO 1 (818) 796-3322

RX REQUESTED

☐ **RX FOR MEDICAL NECESSITY OF AN ORAL APPLIANCE DUE TO CPAP INTOLERANCE**

I would like to start treatment for my mild/moderate/severe obstructive sleep apnea with an oral appliance from Snore Experts because I cannot tolerate my CPAP machine.

A prescription is required from Medicare and/or my Insurance company in order to begin treatment. I would like to request a prescription from your office for medical billing purposes. This prescription is for **MEDICAL NECESSITY OF AN ORAL APPLIANCE DUE TO CPAP INTOLERANCE**.

Please fax the prescription to Snore Experts at 1 (818) 796-3322 as soon as possible as I cannot begin treatment until the prescription is received.

Snore Experts Treatment Centers, founded by Dr. Jonathan Greenburg, are Southern California's most experienced centers for the treatment of severe snoring and obstructive sleep apnea using dental appliances. Their practice is devoted exclusively to the treatment of sleep apnea and snoring.

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