



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 <input type="checkbox"/> MALE <input type="checkbox"/> 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

<input type="checkbox"/> I HAVE BEEN TOLD THAT I "STOP BREATHING" WHEN SLEEPING	<input type="checkbox"/> NIGHTTIME CHOKING SPELLS
<input type="checkbox"/> FEELING UN-REFRESHED IN THE MORNING	<input type="checkbox"/> MORNING HOARSENESS
<input type="checkbox"/> SIGNIFICANT DAYTIME DROWSINESS	<input type="checkbox"/> MORNING HEADACHES
<input type="checkbox"/> DIFFICULTY FALLING ASLEEP	<input type="checkbox"/> TEETH GRINDING
<input type="checkbox"/> FREQUENT HEAVY SNORING	<input type="checkbox"/> JAW CLICKING
<input type="checkbox"/> AFFECTS OTHERS?	<input type="checkbox"/> JAW PAIN
<input type="checkbox"/> OTHER COMPLAINTS: _____	

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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HEALTH HISTORY

FIRST NAME	LAST NAME	DOB
HAVE YOU EVER HAD AN OVERNIGHT SLEEP TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME & LOCATION
IF YES, WHO WAS ORDERING PHYSICIAN?		DATE OF TEST
ARE YOU ALLERGIC TO LATEX? <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU TAKE MEDICATIONS FOR THE FOLLOWING? <input type="checkbox"/> BLOOD PRESSURE <input type="checkbox"/> ANXIETY <input type="checkbox"/> ANTI-DEPRESSANTS <input type="checkbox"/> SLEEPING PILLS
LIST ANY OTHER ALLERGIES:		LIST ANY OTHER MEDICATIONS:
DO YOU WEAR DENTURES? <input type="checkbox"/> YES <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ARTERIOSCLEROSIS	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV	<input type="checkbox"/>	<input type="checkbox"/>
MOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	CONGESTIVE HEART FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DAMAGED HEART VALVES	<input type="checkbox"/>	<input type="checkbox"/>	AUTOIMMUNE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATOID ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	LUPUS	<input type="checkbox"/>	<input type="checkbox"/>
INSOMNIA	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	ACID REFLUX / HEARTBURN	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>
BRAIN FOG	<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DEFECT	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL HEALTH DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
MEMORY LOSS	<input type="checkbox"/>	<input type="checkbox"/>	PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
HEADACHES/MIGRAINES	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY CONCENTRATING	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC PAIN	<input type="checkbox"/>	<input type="checkbox"/>
UNEXPLAINED WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE URINATION	<input type="checkbox"/>	<input type="checkbox"/>
UNEXPLAINED WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>

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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

Form with fields: 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:

Empty text area for reasons for refusal

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:

Empty text area for other therapies

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.

Form with fields: PATIENT SIGNATURE, DATE

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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

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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
<input type="checkbox"/> 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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