TMJ & Sleep Solutions
Mark J. Barnes, DDS

Patient Name_____
FIRST MI LAST

Date of Birth: __/__/_____ How do you wish to be addressed (nickname)_____

Whom may we thank for your referral? _____

What can we help you with? _____

_____

Street Address: _____City: _____ State: ____ Zip: _____

Home #: _____Work #: _____Cell #_____

☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Other_____

E-mail address: _____ Social Security Number: _____
Emergency Contact: _____ Phone: _____
Other family members in this practice: _____

We are a fee for service office and require payment at the time of your visit. (Our returned check fee is $30.00.)

Insurance Information: *We will gladly submit your insurance claim and any necessary information at each visit, as a service. It is your responsibility to follow up with your insurance company for payment. Please let us know if you have any questions.*

Please bring insurance cards to your appointment(s).

Insured's name:_____
Employer's name:_____
Insured's date of birth:_____

Consent and Release of Information

I authorize the release of a full report of examination findings, diagnoses, treatment program, etc. to any referring or treating dentist or physician. I authorize Dr. Mark Barnes, D.D.S., PC and/or his associates to release any information pertinent to my diagnosis or treatment to any third party participating in my health care or insurance coverage.

I certify that the medical history and information is complete and accurate.

Patient Signature: _____Date: _____

Legal Guardian (if not patient): _____Date: _____

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Medical History Questionnaire

Name_____ Date_____

Thank you for being complete and accurate. This information will remain confidential.

MEDICAL HISTORY:
Current Physician:_____Phone:_____
Your last visit to a doctor?_____Why?_____

LIST ANY MEDICATIONS/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:
_____
_____
_____

PAST MEDICAL HISTORY:

- ☐ Acid reflux/GERD
- ☐ AIDS/HIV
- ☐ Artificial joints (hip, knee)
- ☐ Asthma
- ☐ Autoimmune disorders
- ☐ Blood pressure (high or low)
- ☐ Bleeding disorders
- ☐ Cancer/chemotherapy
- ☐ Chemical addictions/Treatment
- ☐ High cholesterol
- ☐ Chronic fatigue/fibromyalgia
- ☐ Cosmetic surgery
- ☐ Depression/anxiety
- ☐ Diabetes/blood sugar
- ☐ Difficulty sleeping
- ☐ Glaucoma/eye problems
- ☐ Head injury/concussion
- ☐ Headaches
- ☐ Heart disease/heart condition
- ☐ Hepatitis
- ☐ Herpes/STD
- ☐ Injury to face or neck
- ☐ Intestinal disorders
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Lung conditions
- ☐ Medical marijuana use
- ☐ Migraines
- ☐ Neck/back/spine conditions
- ☐ Neuralgia
- ☐ Chronic sinusitis
- ☐ Nasal drainage
- ☐ Night sweats/nightmares
- ☐ Osteoarthritis
- ☐ Osteoporosis (Fosamax, etc.)
- ☐ Pacemaker
- ☐ Prostate disease
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Sleep apnea/snoring
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight loss medication (Fen-Phen)
- ☐ Difficulty breathing through nose
- ☐ Other: Use back of form

MEDICATIONS/SUPPLEMENTS:
_____
_____
_____
_____

PAST SURGICAL HISTORY:
_____
_____
_____

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SOCIAL HISTORY: Marital status:_____ Occupation:_____

- ☐ Nonsmoker (never smoked)
- ☐ Ex-smoker
- ☐ Current smoker –How many packs per day? _____

Alcohol consumption:

- ☐ Never
- ☐ Occasional
- ☐ Frequent

FAMILY HISTORY: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your children: _____

REVIEW OF SYSTEMS:

Constitutional:	☐ Weight loss ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats
Eyes:	☐ Blurry vision ☐ Eye pain ☐ Eye discharge
ENT:	☐ Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Congestion ☐ Tinnitus ☐ Sinus problems
Cardiovascular:	☐ Chest pain ☐ Palpitations ☐ Rapid heart rate
Respiratory:	☐ Shortness of breath ☐ Chronic cough
Gastrointestinal:	☐ Nausea ☐ Vomiting ☐ Frequent heartburn ☐ Trouble swallowing
Skin:	☐ Skin sore or ulcers ☐ Mole changes
Musculoskeletal:	☐ Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Joint swelling ☐ Back pain
Psychiatric:	☐ Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Panic attacks ☐ Use of antidepressants
Endocrine:	☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Excess sweating
Neurological:	☐ Seizures ☐ Migraines ☐ Numbness ☐ Dizziness/vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke
Hem/Lymphatic:	☐ Swollen lymph node ☐ Prolonged bleeding ☐ Blood clots
Allergic/Immune:	☐ Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive

DENTAL HISTORY:

Your most recent dentist: _____Date of last dental visit: _____

Do you have dental concerns now? _____

Have you had: (Check all that apply)

☐ Orthodontics (braces) ☐ Implants ☐ Splint/nightguard ☐ Jaw surgery ☐ Periodontal disease (gum disease) ☐ Unusual oral issues/procedures/complications

☐ Problems keeping mouth open

Bite/Jaw Concerns:

☐ Mismatched bite ☐ Hard to relax jaw ☐ Uncomfortable bite ☐ Teeth chipped or worn down ☐ Clenching ☐ Grinding ☐ Difficulty breathing through nose ☐ Trouble swallowing

Other: _____

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Trauma History:
Have you ever been involved in an automobile accident or had other trauma (horses, recreational injury, bike, etc.)?
_____
_____

Additional Information: Use this space to provide any additional information which may be important to your health care.
_____
_____
_____

Please use the back of this form for any additional information if necessary.

_____
Signature of Reviewing Physician Date

_____
Signature of Patient Date

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What Are Your Rights?

You have the right to:

- Request restrictions on certain uses and disclosures of your health information.
- Request that our office communicate your health information privately, with no other family members present or through mailed communications that are sealed and labeled.
- To read and read and review any an all copies of your health information including your complete chart, x-rays, and billing records. There will be a reasonable fee for duplication of your records.
- Ask us to update or modify your records if you believe that your health information records are incomplete or incorrect. There must be a reasonable reason for this change and our office reserves the right to deny this request if the records in question are not created by our office or are inaccurate.
- Request a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations. Please limit these requests to no more than six years at a time. There may be a reasonable charge for these duplications.
- To obtain a copy of these privacy notices directly from our office at any time.
- To express complaints to us or the Secretary of Health and Human Services if you believe that your privacy rights have been compromised. We encourage you to express any concerns that you may have. Thank you for communicating your complaints in writing.

We are required by law to maintain the privacy of your health information and provide you and/or your representative this notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. If there is a change, we will be sure that each patient receives a copy of the revised Notice. By signing below, I give the TMJ and Sleep Solutions permission to use the contact information I have provided to confirm appointments and contact me via phone, e-mail, or USPS.

Patient Acknowledgement

Patient Name(s)_____

Thank you very much for taking the time to review our procedures in protecting your private health information. If you have any questions, please feel free to ask any member of the staff in our office. Please sign and return this form to acknowledge your understanding of the information.
Thank you!

Signature: _____
*Date:*_____

General Affidavit for CPAP Intolerance

Patient Name:_____ Date:_____

I, _____ make my statement and general affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts, and things set forth are true and correct to the best of my knowledge.

I have been prescribed the CPAP to manage my sleep related breathing disorder and find it intolerable to use on a regular basis due to the following reasons:

_____ Mask leaks

_____Mask/device is uncomfortable

_____Unable to sleep comfortably

_____Noise of the CPAP disturbs sleep and/or bed partners sleep

_____Movement is restricted during sleep

_____Does not seem to be effective

_____Straps/headgear cause discomfort

_____Pressure on the upper lip cause tooth related problems

_____Latex allergy

_____Claustrophobia

_____Pre-existing sinus condition

_____Other_____

Because of my intolerance/inability to use the CPAP machine, I wish to have an alternative method of treatment. That treatment is an Oral Airway Dilator as prescribed by Dr. Mark J. Barnes.

_____ _____/_____/_____

Patient Signature Date

BRAEBON
For Today's Business of Sleep™

Instructions: Complete the form.
Fax completed form to 613-831-6699

NAME:	AGE:	HEIGHT (ft in):	HEIGHT (cm):
DATE of BIRTH:	WEIGHT (lbs):		WEIGHT (kg):
TELEPHONE:	DO YOU SMOKE? ☐ NO ☐ YES		QUIT IN (year)
REFERRING MD:	GENDER: ☐ Male	☐ Female	
DO YOU FEEL YOU MAY HAVE OSA? ☐ NO ☐ YES	BMI:	NECK SIZE (in):	(cm):
CITY of RESIDENCE:	STATE / PROVINCE:		

Instructions: Use the scale below to choose the most appropriate number for each situation. Use the drop-down menu or assign a number and sum the numbers at the bottom:
0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation	Chance of Dozing
Sitting and reading	0
Watching TV	0
Sitting inactive in a public place	0
As a passenger in a car for an hour	0
Laying down in the afternoon	0
Sitting and talking to someone	0
Sitting quietly after lunch (no alcohol)	0
In a car and stopped for a few minutes	0
Total Score	0 /24

Please choose (✓) the correct response to each question:

CATEGORY 1

1. ***DO YOU SNORE?***
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know
2. ***IF YOU SNORE:***
   Your SNORING is
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Louder than talking - can be heard in adjacent rooms
3. ***HOW OFTEN DO YOU SNORE?***
   - ☐ Nearly everyday
   - ☐ 3 - 4 times a week
   - ☐ 1 - 2 times a week
   - ☐ 1 - 2 times a month
   - ☐ Never or nearly never
4. ***HAS YOUR SNORING BOTHERED OTHER PEOPLE?***
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know
5. ***HAS ANYONE NOTICED THAT YOU QUIT BREATHING IN YOUR SLEEP?***
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never, or nearly never

BRAEBON
For Today's Business of Sleep™

Instructions: Complete the form.
Fax completed form to 613-831-6699

Please choose (✓) the correct response to each question:

CATEGORY 2

6. ***HOW OFTEN DO YOU FEEL FATIGUED OR TIRED AFTER YOUR SLEEP?***
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never, or nearly never

7. ***DURING YOUR WAKING TIME, DO YOU FEEL TIRED, FATIGUED or NOT UP TO PAR?***
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never, or nearly never

8. ***HAVE YOU EVER FALLEN ASLEEP or NODDED OFF DRIVING A VEHICLE?***
- ☐ Yes
- ☐ No

9. ***IF YES, THEN HOW OFTEN DOES THIS OCCUR?***
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never, or nearly never

CATEGORY 3

10. ***DO YOU HAVE HIGH BLOOD PRESSURE?***
- ☐ Yes
- ☐ No
- ☐ Don't Know

SLEEP SYMPTOMS - Please (✓) all that apply to you:

- ☐ frequent bathroom visits nightly
- ☐ gasping, choking or snorting during sleep
- ☐ restless legs
- ☐ limbs jerking/twitching at night
- ☐ morning headache
- ☐ insomnia
- ☐ restless sleep
- ☐ memory loss
- ☐ teeth grinding/clenching
- ☐ waking up paralysed
- ☐ audible or visual hallucinations around sleep
- ☐ family history of sleep apnea

PREVIOUS SLEEP DIAGNOSES & TREATMENT

- ☐ Overnight Oximetry
- ☐ MediByte / Type 3 Test
- ☐ Sleep Study in Lab
- ☐ CPAP / BiLevel Therapy
- ☐ Dental Splint for Snoring or OSA

HEALTH ISSUES - Please (✓) all that apply to you:

- ☐ Heart disease
- ☐ Stroke
- ☐ COPD
- ☐ Other Lung Disease
- ☐ Gastric Acid Reflux
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Oxygen use
- ☐ Pacemaker
- ☐ Depression
- ☐ Erectile Dysfunction
- ☐ Alcohol consumption
  Specify:
  - ☐ Daily
  - ☐ 3-5 times weekly
  - ☐ Weekly
  - ☐ Weekends
  - ☐ Special Occasions
- ☐ Previous oral/nasal surgery (if yes, describe below)
- ☐ Other (specify): _____

MEDICATIONS (Names only, no doses)

I hereby attest all answers are truthful:
Signature: _____
Date (mm/dd/yy):