



**Jennifer Q. Le, DMD, D-ABDSM, CPCC, ACC**  
Diplomate of American Board of Dental Sleep Medicine

## Dental Patient Registration

### Patient Information

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Email address: \_\_\_\_\_

By checking this box I agree to receive communications from the office regarding updates and promotions.

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

How long has it been since your last dental exam? \_\_\_\_\_

### Insurance Information – Provide office with insurance card

Patient's Relationship to Insurance Carrier:  Self  Spouse  Child  Other

Name of Insured if not patient: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Insured Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_ Insured Soc Sec: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

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**Medical History**

**NAME:** \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- |                                                            |                           |                          |                               |
|------------------------------------------------------------|---------------------------|--------------------------|-------------------------------|
| Are you under a physician's care now?                      | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation?  | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury?           | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs?           | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux?         | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Are you on a special diet?                                 | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you use tobacco?                                        | <input type="radio"/> Yes | <input type="radio"/> No |                               |
| Do you use controlled substances?                          | <input type="radio"/> Yes | <input type="radio"/> No |                               |
| Are you HIV Positive or have you been diagnosed with AIDS? | <input type="radio"/> Yes | <input type="radio"/> No |                               |

- Women: Are you
- Pregnant/Trying to get pregnant?
  - Nursing?
  - Taking Oral Contraceptives?

Are you allergic to any of the following?

<input type="radio"/> Aspirin	<input type="radio"/> Penicillin	<input type="radio"/> Codeine	<input type="radio"/> Acrylic	<input type="radio"/> Metal	<input type="radio"/> Latex	<input type="radio"/> Local Anesthetics
<input type="radio"/> Other	If yes, please explain: _____					

- Do you have, or have you had, any of the following?
- |                                              |                                                 |                                             |                                             |                                                  |
|----------------------------------------------|-------------------------------------------------|---------------------------------------------|---------------------------------------------|--------------------------------------------------|
| <input type="radio"/> AIDS/HIV Positive      | <input type="radio"/> Chest Pains               | <input type="radio"/> Frequent Headaches    | <input type="radio"/> Irregular Heartbeat   | <input type="radio"/> Scarlet Fever              |
| <input type="radio"/> Alzheimer's Disease    | <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Genital Herpes        | <input type="radio"/> Kidney Problems       | <input type="radio"/> Shingles                   |
| <input type="radio"/> Anaphylaxis            | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Glaucoma              | <input type="radio"/> Leukemia              | <input type="radio"/> Sickle Cell Disease        |
| <input type="radio"/> Anemia                 | <input type="radio"/> Convulsions               | <input type="radio"/> Hay Fever             | <input type="radio"/> Liver Disease         | <input type="radio"/> Sinus Trouble/Sleep Apnea  |
| <input type="radio"/> Angina                 | <input type="radio"/> Cortisone Medicine        | <input type="radio"/> Heart Attack Failure  | <input type="radio"/> Low Blood Pressure    | <input type="radio"/> Spina Bifida               |
| <input type="radio"/> Arthritis/Gout         | <input type="radio"/> Diabetes                  | <input type="radio"/> Heart Murmur          | <input type="radio"/> Lung Disease          | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Drug Addiction            | <input type="radio"/> Heart Pace Maker      | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke                     |
| <input type="radio"/> Artificial Joint       | <input type="radio"/> Easily Winded             | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Pain in Jaw Joints    | <input type="radio"/> Swelling of Limbs          |
| <input type="radio"/> Asthma                 | <input type="radio"/> Emphysema                 | <input type="radio"/> Hemophilia            | <input type="radio"/> Parathyroid Disease   | <input type="radio"/> Thyroid Disease            |
| <input type="radio"/> Blood Disease          | <input type="radio"/> Epilepsy or Seizures      | <input type="radio"/> Hepatitis A           | <input type="radio"/> Psychiatric Care      | <input type="radio"/> Tonsillitis                |
| <input type="radio"/> Blood Transfusion      | <input type="radio"/> Excessive Bleeding        | <input type="radio"/> Hepatitis B or C      | <input type="radio"/> Radiation Treatments  | <input type="radio"/> Tuberculosis               |
| <input type="radio"/> Breathing Problem      | <input type="radio"/> Excessive Thirst          | <input type="radio"/> Herpes                | <input type="radio"/> Recent Weight Loss    | <input type="radio"/> Tumors or Growths          |
| <input type="radio"/> Bruise Easily          | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> High Blood Pressure   | <input type="radio"/> Renal Dialysis        | <input type="radio"/> Ulcers                     |
| <input type="radio"/> Cancer                 | <input type="radio"/> Frequent Cough            | <input type="radio"/> Hives or Rash         | <input type="radio"/> Rheumatic Fever       | <input type="radio"/> Venereal Disease           |
| <input type="radio"/> Chemotherapy           | <input type="radio"/> Frequent Diarrhea         | <input type="radio"/> Hypoglycemia          | <input type="radio"/> Rheumatism            | <input type="radio"/> Yellow Jaundice            |

None of the conditions listed

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Please check the option that best applies:

	Never	Once per week	Several days per week	Daily
How often do you consume alcohol within 2-3 hours of bedtime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you take sedatives within 2-3 hours of bedtime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you consume caffeine within 2-3 hours of bedtime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Occasionally	Daily	Number of cigarettes per day
Do you use tobacco? (Smoking, snuff, or chew)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check if any members of your family have had:

- Heart disease
- High blood pressure
- Diabetes
- Cancer
- Diagnosed or treated for a sleep disorder



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**Medical History Continued:**

**Current Primary Care Physician Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### Section A-Patient Giving Consent

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

Patient # \_\_\_\_\_ Social Security # \_\_\_\_\_

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### Section B-TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations at the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice at any time by contacting:

Contact Person: Jennifer Q. Le, DMD

Telephone: 919-488-0111

Fax: 919-488-0104

Address: 2810-115 Wakefield Pines Drive, Raleigh, NC 27614

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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**\*You May Refuse to Sign This Acknowledgement\***

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**Office Policies**  
Effective 04/26/2006

- **A complete exam includes x-rays.** The x-rays consist of 4 Bitewing x-rays, a panoramic x-ray and periapical (root x-ray) x-rays of certain teeth. Anything not covered by insurance will be your responsibility. If you have recent x-rays (bite wings less than one year and panoramic less than three years) at another dentist we ask you to have them emailed to us.
- If you have not had regular dental care it may be necessary to perform a general debridement in order to diagnose the health of your gums. A scaling and root planing may be recommended in some case. If either of these procedures is necessary the hygienist will discuss this with you prior to treatment.
- An adult, 18 years old or older, must accompany all patients under the age of 18. A signed waiver may be accepted from a parent/guardian for certain procedures.
- Your estimated portion is due at the time service is rendered. There are times when an insurance company will pay more than expected. In these circumstances any money owed to the patient under the amount of \$100.00 will be left as a credit on the account. Refunds will be mailed within 4 to 6 weeks.
- Patients that cancel without a **24-hour notice** or no show will be charged a cancellation fee of **\$25.00 per half hour**.
- We are happy to file insurance for you but please be aware that any portion not paid by your insurance will be your responsibility. We contact your insurance company prior to your new patient appointment to verify benefits and to obtain a general benefits breakdown. We will give you an estimate for any proposed treatment however it is your responsibility to be familiar with your dental plan. We are not responsible for any discrepancies between our estimate and the actual payment from your insurance company.

**PLEASE NOTICE:**

It is our office philosophy to try to provide our patients with the most up to date techniques and materials available in dentistry. When doing fillings, we use composite resin (tooth colored fillings) because they allow a more conservative and esthetic result. Amalgam (silver) fillings are reserved for circumstances when proper isolation is difficult. We understand that you may prefer to have amalgam fillings. If so, we can refer you to a dentist nearby.

**Some insurance companies do not cover composite resins, only amalgam (silver).** Once Dr. Le has gone over your treatment plan with you we will give you a print out of the total **estimated** charges. The **estimate** will have a break down of your portion and the insurance portion. We will not know the exact amount of coverage until the claim has been submitted, and we receive payment.

We appreciate the opportunity to provide you with care, in understanding that these office policies help our office run smoothly. If you would like a copy of our office policies please let us know.

I \_\_\_\_\_ have read the information and fully understand its content.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Compound Authorization for Release of Information

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Wakefield Family Medicine & Dentistry** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment absentee information
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Parent (provide name)	<input type="checkbox"/> Family Billing Information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Other (provide name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows
<input type="checkbox"/> Support Group (provide name)	<input type="checkbox"/> Demographic Information

### Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Wakefield Family Medicine & Dentistry.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Date \_\_\_\_\_

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation) \_\_\_\_\_

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## Getting To Know You!

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_

List all family members currently seen at our office: \_\_\_\_\_  
\_\_\_\_\_

Who selected our office?  Self  Spouse  Parent  Employer

How did you hear about our office? \_\_\_\_\_

- Referred by friend   
  Yellow Pages   
  Relative   
  Insurance Plan   
  Welcome Wagon  
 TV/Radio   
  Newspaper   
  Direct Mailing   
  Sign by Building   
  Other \_\_\_\_\_

### Dental History

Do you floss? Y / N  
If yes, how often? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

(Please circle each that applies to you)

- Y N I clench or grind my teeth during the day or while sleeping    Y N My gums feel tender or swollen.  
 Y N My gums bleed while brushing or flossing.  
 Y N I have had a facial or jaw injury.  
 Y N I avoid brushing part of my mouth due to pain.  
 Y N I have a history of oral cancer.  
 Y N I've been told previously I have gum disease.

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**Answer Y or N**

***Functional Outcomes of Sleep Questionnaire***

- |                                                                                                                                                                                                                      |                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Q1. Do you generally have difficulty concentrating on the things you do because you are sleepy or tired?                                                                                                             | Q16. Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?                                                  |
| Q2. Do you generally have difficulty remembering things because you are sleepy or tired?                                                                                                                             | Q17. Do you have difficulty watching a movie or videotape because you become sleepy or tired?                                                                        |
| Q3. Do you have difficulty finishing a meal because you become sleepy or tired?                                                                                                                                      | Q18. Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?                                                                    |
| Q4. Do you have difficulty working on a hobby (for example: sewing, collecting, gardening) because you are sleepy or tired?                                                                                          | Q19. Do you have difficulty enjoying a concert because you become sleepy or tired?                                                                                   |
| Q5. Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?                                              | Q20. Do you have difficulty watching television because you are sleepy or tired?                                                                                     |
| Q6. Do you have difficulty operating a motor vehicle for short distances ( <u>less</u> than 100 miles) because you become sleepy or tired?                                                                           | Q21. Do you have difficulty participating in religious services, meetings or a group or club because you are sleepy or tired?                                        |
| Q7. Do you have difficulty operating a motor vehicle for long distances ( <u>greater</u> than 100 miles) because you become sleepy or tired?                                                                         | Q22. Do you have difficulty being as active as you want to be in the <u>evening</u> because you are sleepy or tired?                                                 |
| Q8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?                                                                                           | Q23. Do you have difficulty being as active as you want to be in the <u>morning</u> because you are sleepy or tired?                                                 |
| Q9. Do you have difficulty taking care of financial affairs and doing paperwork (for example: writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired? | Q24. Do you have difficulty being as active as you want to be in the <u>afternoon</u> because you are sleepy or tired?                                               |
| Q10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?                                                                                                                   | Q25. Do you have difficulty keeping pace with others your own age because you are sleepy or tired?                                                                   |
| Q11. Do you have difficulty maintaining a telephone conversation because you become sleepy or tired?                                                                                                                 | Q26. <b>For Question 26 only, answer using the scale below.</b><br>How would you rate your general level of activity?<br>1 = Very Low; 2 = Low; 3 = Medium; 4 = High |
| Q12. Do you have difficulty visiting with your family or friends in <u>your</u> home because you become sleepy or tired?                                                                                             | Q27. Has your intimate or sexual relationship been affected because you are sleepy or tired?                                                                         |
| Q13. Do you have difficulty visiting with your family or friends in <u>their</u> home because you become sleepy or tired?                                                                                            | Q28. Has your desire for intimacy or sex been affected because you are sleepy or tired?                                                                              |
| Q14. Do you have difficulty doing things for your family or friends because you are too sleepy or tired?                                                                                                             | Q29. Has your ability to become sexually aroused been affected because you are sleepy or tired?                                                                      |
| Q15. <b>For Question 15 answer using only 1, 2, 3 or 4.</b> Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?                                             | Q30. Has your ability to have an orgasm been affected because you are sleepy or tired?                                                                               |

The FOSQ questions are complete.  
Thank you for completing this questionnaire.

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**The Epworth Sleepiness Scale**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Your Age (years): \_\_\_\_\_

Your Sex:     \_\_\_ Male     \_\_\_ Female

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 choose the **most appropriate number** for each situation.

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

<b>Situation:</b>	<b>Chance of Dozing</b>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
<b>TOTAL</b>	_____

**UNDERSTANDING YOUR SCORE**

0–10: Normal range in healthy adults

11–14: Mild sleepiness

15–17: Moderate sleepiness

18 or higher: Severe sleepiness

If you scored 11 or higher, consider seeing a sleep medicine specialist to diagnose and treat the cause of your sleepiness.



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**AFFIDAVIT FOR INTOLERANCE TO CPAP**

Name: \_\_\_\_\_

I have attempted to use nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s):

- Mask leaks
- Mask uncomfortable / Device uncomfortable
- Unable to sleep comfortably
- Noise disturbs my sleep and/or bed partner's sleep
- Restricts movement during sleep
- Does not seem to be effective
- Straps/head gear cause discomfort
- Pressure on the upper lip cause tooth related problems
- Latex allergy
- Claustrophobic
- An unconscious need to remove in the night
- Other \_\_\_\_\_

Because of my intolerance to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is an oral appliance for mandibular repositioning as prescribed to me by Dr. Jennifer Q. Le, DMD.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



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## Dental History

Current Dentist:

---

Practice Name:

---

Practice Address:

---

Practice Phone Number:

---

Date of Last Dental Exam:

---

Date of Last Radiographs:

---

I, \_\_\_\_\_ confirm that I do NOT have any outstanding dental treatment that has been proposed.

I, \_\_\_\_\_ acknowledge that any x-rays (including panoramic) that are necessary for my treatment are my responsibility if not covered by my insurance.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_