Pacific Coast
Dental Sleep
Medicine

Andrew S. Firtel, D.D.S.

Dental Sleep Medicine; Oral Appliance Therapy for Obstructive Sleep Apnea

Patient Information

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Occupation: _____ Social Security #: _____ Birthdate: _____

Marital status: _____ Name of Spouse: _____

Purpose of Visit: _____

Briefly list chief complaint: _____

Whom can we thank for referring you to the office: _____

Emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Information

Insurance Company: _____ ID number: _____

Group Policy Number: _____ Insured SSN: _____

Insurance Address: _____ Phone #: _____

Insured Birthday: _____ Insured Name: _____

Health History

__ Anemia __ Diabetes type II __ Diabetes type I __ Epilepsy/Seizure __ Bleeding Disorder

__ Heart Surgery __ Artificial Heart Valve __ Congenital Heart Defect __ Heart Murmur

__ Rheumatic Fever __ Mitral Valve Prolapse __ Kidney Disease

__ Heart Disease __ Pacemaker __ High Blood Pressure __ Allergy to Latex __ Tuberculosis

__ Prosthetic Joint (knee, hip, or other) __ Hepatitis/Liver Disease __ Infectious Disease (HIV or AIDS)

__ Asthma or other breathing disorder __ Allergies: _____

__ Other: *please explain* _____

Are there any other health problems of importance? _____

_____

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Are you taking any medications? If YES, please list below (over the counter and prescription):

1. _____ 2. _____

3. _____ 4. _____

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

For women, are you pregnant? ___ NO ___ YES Are you taking birth control? ___ NO ___ YES

Name of your Primary Care Physician: _____ Phone: _____

Address: _____

Please list the names of any doctors or health care professionals you are seeing on a regular basis:

Name	Phone Number	Reason or condition being treated
1.		
2.		

Lifestyle and Physical Activities

Do you use tobacco? ___NO ___YES Type: ___ cigarettes ___ packs per day ___ smokeless

Drink alcohol? ___NO ___ YES ___ Drinks per week

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 available reports, a clinical examination, which is followed by a consultation and discussion of the findings and the recommended course of treatment.

Signature: _____

Authorization to Submit Insurance Claim

I authorize Dr. Firtel 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. Firtel 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. Firtel. After 90 days I accept full responsibility for payment to Dr. Firtel

Signature: _____

Authorization for Release of Health Information

I authorize Dr. Firtel 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: _____