

# WELCOME TO OUR OFFICE



**Thank you** for choosing us to help you with your dental care! Our pledge is to help you have a **healthy and happy smile, a SMILE FOR LIFE**. In addition to providing advanced, comprehensive dentistry, we hope to develop a **lifelong relationship** with each of our patients. We pride ourselves in treating you as we would want to be treated by offering caring, **quality dental services**.

It is very important that we maintain **open communication** with you at all times. If at any time we can be of assistance to you regarding our services, dental information or finances, we urge you to **speak to our staff**. To help you best, please provide the following information.

Very Sincerely,

Ron M. Ask, DDS, Craig A. Kinzer, DDS, Dwight D. Simpson, DDS, Leon Roda III, DDS, Jerhet R. Ask, DDS

## DENTAL HISTORY

Name \_\_\_\_\_

Date \_\_\_\_\_

How can we help you today? \_\_\_\_\_

Former Dentist: \_\_\_\_\_

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

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

Date of last x-rays and exam: \_\_\_\_\_

Date of last cleaning: \_\_\_\_\_

NO  YES Have you ever had orthodontic treatment? When? \_\_\_\_\_

NO  YES Have you ever had periodontal treatment, such as deep cleaning/root planning or surgery?

NO  YES Do you have to be pre-medicated with antibiotics before a cleaning or major dental work?

NO  YES Are you anxious about having dental treatment? Why? \_\_\_\_\_

NO  YES **Has fear prevented you from seeking dental treatment? Why?** \_\_\_\_\_

NO  YES Would you like a sedative to help you relax, i.e. Valium or Nitrous Oxide (laughing gas)?

NO  YES Are you fearful of losing your natural teeth in your lifetime?

NO  YES Have you ever had complications from dental treatment? What? \_\_\_\_\_

NO  YES Are your teeth sensitive/painful to hot/cold or anything else? Explain: \_\_\_\_\_

NO  YES Does food get caught between your teeth? Where? \_\_\_\_\_

NO  YES Do you have difficulty chewing on both sides of your mouth? Which side? \_\_\_\_\_

NO  YES Are you aware of clenching or grinding your teeth?

NO  YES Do you have bad breath problems?

NO  YES Have you bleached your teeth in the past? What method? \_\_\_\_\_

What did you like the **most** about any dentist you have seen? \_\_\_\_\_

What did you like the **least** about any dentist you have seen? \_\_\_\_\_

Rate your smile from 1 to 10 (1=Worst 10=Best): \_\_\_\_\_

What would it take, in your opinion, to get your smile to a "10"? \_\_\_\_\_

Do you prefer to learn every detail of your dental care **OR** just an overall explanation? \_\_\_\_\_

Would you like to be presented with the best dentistry has to offer for your long-term health **OR** be presented with the basics to get you by for several years? \_\_\_\_\_

## FAMILY INFORMATION

Parents (if patient is a child): \_\_\_\_\_ Spouse: \_\_\_\_\_

Name Age Name Age Name Age

Children: \_\_\_\_\_

Children: \_\_\_\_\_

Emergency Contact/Nearest Relative NOT living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

# MEDICAL HISTORY

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

*Your health problems that you have or medication that you are taking could have an important relationship with your dental treatment. Thank you for allowing us to know you better and be appropriate with our dental care.*

Are you in good health now?  Yes  No      Are you under the care of a physician?  Yes  No

Your Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been hospitalized or had a serious illness?  Yes  No

Explain: \_\_\_\_\_

Do you have: Please check

NO  PAST  NOW

**EYES/EARS/NOSE/THROAT**

- Glaucoma
- Ear aches
- Ear infections
- Loss of hearing
- Ringing in ears
- Frequent nosebleeds
- Sinus problems

**NERVOUS SYSTEM**

- CVA or Stroke
- Convulsions/Epilepsy
- Numbness/Tingling
- Dizziness/Fainting
- Psychiatric care

**RESPIRATORY SYSTEM**

- Hay fever
- Tuberculosis
- Asthma
- Difficulty breathing
- Emphysema

**CIRCULATORY SYSTEM**

- Rheumatic fever
- Heart murmur
- Mitral valve prolapsed
- Arteriosclerosis
- Chest discomfort/pain
- Heart attack/trouble
- Swelling of ankles
- Shortness of breath
- Congestive heart failure
- Artificial heart valve
- Pacemaker
- Congenital heart disease

High blood pressure

Other \_\_\_\_\_

**ENDOCRINE**

- Diabetes
- Family history of diabetes
- Hypoglycemia
- Thyroid condition
- Other \_\_\_\_\_

**DIGESTIVE SYSTEM**

- Hepatitis A (infectious)
- Hepatitis B (serum)
- Hepatitis C
- Jaundice/liver issues
- Ulcers/Stomach issues
- Special diets
- Cold sores

**URINARY SYSTEM**

- Kidney disease
- Increase in frequency

**BLOOD SYSTEM**

- Abnormal bleeding
- Bleeding tendency
- Bruise easily
- Anemia
- Blood transfusions
- HIV Positive/AIDS

**OTHER**

- Osteoporosis
- Arthritis/Rheumatism
- Artificial limb or joint
- Venereal disease
- Cancer
- Chemo/radiation therapy
- Are you pregnant?

**DIETARY**

- Food allergies
- Alcohol >2 times/week
- Cigarettes, Quantity \_\_\_\_\_
- Tobacco use
- Recreational drugs

**SLEEP DEPRIVATION DISEASE**

- Do you snore?
- Restless sleeper
- Chronically tired
- Decreased in energy
- Depression
- Gasp for air at night
- Sleep apnea

**CRANIO-MANDIBULAR**

**DISORDERS**

- Tension headaches
- How often? \_\_\_\_\_ Since: \_\_\_\_\_
- Migraine headaches
- Neck/Back problems
- Involved in car accident
- Clench or grind teeth
- Clicking jaw joints
- Jaws lock

**ALLERGIES**

- Latex gloves
- Local anesthetic (novocaine)
- Penicillin
- Erythromycin
- Aspirin or Codeine
- Sulfa drugs
- Metals
- Other \_\_\_\_\_

Are you taking any **MEDICATIONS**?  NO  YES If so, list medications and for what use:

Med: \_\_\_\_\_ Why? \_\_\_\_\_ Med: \_\_\_\_\_ Why? \_\_\_\_\_

Med: \_\_\_\_\_ Why? \_\_\_\_\_ Med: \_\_\_\_\_ Why? \_\_\_\_\_

Is there any other disease, condition or problem that you think we should know about?  NO  YES

Please explain: \_\_\_\_\_

*I hereby state that this medical history form is correct to the best of my knowledge.*

**Signature** (Guardian's Signature if Patient is a minor): \_\_\_\_\_

Annual Review Date (patient): \_\_\_\_\_ Initial: \_\_\_\_\_ Annual Review Date: \_\_\_\_\_ Initial: \_\_\_\_\_

Annual Review Date (provider): \_\_\_\_\_ Initial: \_\_\_\_\_ Annual Review Date: \_\_\_\_\_ Initial: \_\_\_\_\_



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**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last First MI

D.O.B. \_\_\_\_\_ Gender(M/F): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

Street Apartment #

City State Zip Code

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

Phone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Other \_\_\_\_\_ Best Phone Number to Call (circle): Home / Work / Cell / Other

**Referral Information**

Whom may we thank for referring you to our office? \_\_\_\_\_

**Spouse or Responsible Party Information**

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

Last First MI

D.O.B. \_\_\_\_\_ Gender(M/F): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

Street Apartment #

City State Zip Code

Phone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Other \_\_\_\_\_ Best Phone Number to Call (circle): Home / Work / Cell / Other

Insurance Plan Name: \_\_\_\_\_

Group # \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

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

Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

**In Office Use Only**

Patient Coordinator Data Entry \_\_\_\_\_ Reception Coordinator 5mRX \_\_\_\_\_  
Initial Date Completed Initial Date Completed

*Advanced Comprehensive Dentistry & Orthodontics*

100 French Bar Road • Suite 101 • Jackson, CA 95642 • Phone (209) 223-2712 • FAX (209) 223-2719

www.JacksonCreekDental.com



Jackson Creek Dental Group  
—Smiles for Life

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## HELP US HELP YOU

**We take our responsibility to fulfill our pledge to you very seriously. Building a long-term quality relationship with you is one of our highest goals. In order for us to fulfill our pledge to you, we need your help.**

### **May we ask you to strive for the following:**

**TO have an open mind to learn, have a positive attitude and be motivated to become actively involved in preventing dental disease in my own mouth. My best and most effective job is to help prevent dental disease in my mouth.**

**TO want and do what I am able, to have a pleasing and healthy smile and to keep my own teeth for a lifetime, free of pain and disease.**

**TO expect the highest quality dental services available anywhere in the world, when treatment is necessary.**

**TO communicate my concerns, needs and wants to the dental team, to help JCDG ensure that the dental procedures will be performed with the utmost appropriateness and comfort.**

**TO be committed to the appointment time decided upon together.**

**TO expect a pretreatment estimate, and then to meet my financial obligation on the day my dental services are provided.**

**TO treat the JCDG staff as I wish to be treated.**

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Jackson Creek Dental Group

## PLEDGE to PATIENTS

**We pledge** to **educate, encourage and inspire** you to become actively involved in preventing dental disease in your own mouth. Our best and most effective job is to help **prevent** dental disease instead of repairing the damage of the disease.

**We pledge** to help you have a **pleasing and healthy smile** and to keep your own teeth for a lifetime, free of pain and disease.

**We pledge**, when treatment is necessary, to provide the **highest quality** dental services available anywhere in the world.

**We pledge** that routine dental procedures will be performed with the **utmost comfort**.

**We pledge** to be **available** when you need us.

**We pledge** to offer you financial alternatives so that quality dentistry can be **affordable** to you.

**We pledge** to improve the overall dental health in our **community**.

**We pledge** to treat you **as we wish to be treated**.

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## FINANCIAL POLICY

**IT IS OUR RESPONSIBILITY TO GIVE YOU A PRE-TREATMENT ESTIMATE. IT IS YOUR RESPONSIBILITY TO PAY FOR DENTAL SERVICES THE DAY THEY ARE DONE.** We will accept cash, personal check, Visa Card or MasterCard. Other external financial options are available for those who desire a **payment plan**. An application is available from your doctor's patient coordinator, and credit approval can usually be obtained over the phone in less than one day. Once the financial arrangements and conditions of treatment are agreed upon, should it become necessary to place this account for collection, you agree to pay all costs and expenses thereof.

**APPOINTMENTS:** To keep the cost of dentistry as low as possible, appointments are scheduled to best fit the doctor's, the hygienist's and the patient's busy schedules. These **appointments are a contract of time reserved specifically for you**. A **48 business hour notice is needed and required** to reschedule your appointment to adequately allow time to help another patient. There will be a charge for any missed or rescheduled appointments with less than 48 business hour notice. **Please do not put us or yourself in this uncomfortable situation.**

### FOR OUR INSURANCE PATIENTS

You have a direct relationship with your insurance company, most likely through your employer. You also have a direct relationship with your doctor. Your doctor does not have a relationship with your employer or your insurance company. Therefore, financial arrangements are made with you and not your insurance company. **YOU ARE TOTALLY RESPONSIBLE FOR YOUR ENTIRE DENTAL BILL.**

**HOWEVER**, we will quote fees, and from the information you give us we will ESTIMATE (**APPROXIMATE**) the amount your insurance company will most likely pay as covered benefits under the terms of your contract. If you have any questions about your treatment, the cost, or need help in determining your coverage, please call our office. Our staff is highly trained to help you. **Most plans do not pay for the entire cost of your care.** Do not proceed with treatment until you understand what is financially expected of you. It is your responsibility to be sure you are **eligible** for treatment when dental services are provided. There may be a deductible, a yearly maximum, a reduced fee table, or other limitations and/or excluded services. The most **frequent areas of misunderstandings** are clauses relating to "least adequate care provision" (only covering silver fillings in the back of the mouth instead of the newer, better, bonded white fillings), "general limitations" (non duplication of benefits with dual insurance, or no "prior extraction" coverage for bridges) and "pre-authorizations" (usually not required).

**We will accept assignment of benefits.** This means we will collect your estimated co-payment when treatment is rendered and process your initial claim. You are **authorizing** us to release all necessary **information** to your insurance company to secure the **payment of benefits, for which you are entitled, directly to the dental office.** **We will wait 90 days after your treatment for payment by your insurance company, after which it is your obligation to pay the entire amount due.** There will be a finance charge in the amount of 2% per month, or 24% annually, on any balance over 90 days.

We are **now successfully billing medical insurance** for medical problems best treated by us as dentists. We **do not accept assignment of benefits** as we do for dental insurance. You will be expected to pay for any treatment for which we bill medical and then you **may** be reimbursed by your medical insurance.

If your insurance company does not pay what you expected or would like, please remember that your **insurance company should not decide your dental health. YOU SHOULD!** In the event you do not receive the benefits from your insurance carrier which you believe you are entitled, contact your employer's benefits department, your insurance representative, your union agent or the State Attorney General's office.



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## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices, and applicable law permits the same. We reserve the right to make the changes in our privacy practices, and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$.25 for each page, \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

A copy of our "Protected Health Information (PHI) Breach Policy" is available upon request.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Practice Administrator  
Address: 100 French Bar Road, Suite #101, Jackson, CA 95642  
Telephone: 209.223.2712 Fax: 209.223.2719  
E-mail: administrator@jacksoncreekdental.com

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



## CONSENT FOR TREATMENT

- Yes  No I authorize necessary x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
- Yes  No I authorize the doctors of Jackson Creek Dental Group to perform all recommended treatment mutually agreed upon by me. I authorize the use of appropriate anesthetics and medicines indicated for such treatment.
- Yes  No I will ask questions to understand the consequences of NOT having the needed dental work done.
- Yes  No I have received a copy of the financial and appointment policy. I understand and accept these office policies.
- Yes  No I am aware that the office "Notice of Privacy Practices" is posted and is available in the reception room.
- Yes  No I authorize Jackson Creek Dental Group to discuss my medical condition with:

\_\_\_\_\_

*Name*

\_\_\_\_\_

*Relationship*

I authorize Jackson Creek Dental Group to leave a detailed medical message on my:

- Yes  No **Cell phone**
- Yes  No **On my email**
- Yes  No **Answering machine at home**
- Yes  No **Place of employment**

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

*(Please Print)*

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

*(Parent's Signature if Patient is a Minor)*

Annual Review Date: \_\_\_\_\_ Initial: \_\_\_\_\_ Annual Review Date: \_\_\_\_\_ Initial: \_\_\_\_\_

Annual Review Date: \_\_\_\_\_ Initial: \_\_\_\_\_ Annual Review Date: \_\_\_\_\_ Initial: \_\_\_\_\_



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## Sleep Apnea Screener

Sleep disorders have recently been noted to be a major cause of a variety of dental and medical problems. These problems include bruxism, clenching, tooth erosion, headaches, fatigue, TMJ problems, hypertension, heart disease, strokes, diabetes and gastric reflux. Sleep disorders have become an epidemic in our society due to allergies and weight gain. Research has shown that 50% of men and 30% of women suffer from sleep disorders in a typical practice.

Because our practice is committed to your total health care, we have added sleep disorder dentistry to our practice. Please fill out the following sleep disorder questionnaire so that we may completely evaluate your health.

<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>			
<b>1. On average in the past month, how often have you snored or been told you snore?</b>					
<input type="radio"/> Never <input type="radio"/> Rarely (>1/week) <input type="radio"/> Sometimes (1-2/week) <input type="radio"/> Frequently (3-4/week) <input type="radio"/> Almost Always (5-7/week)					
<b>Date of Birth:</b>	<b>Age:</b>	<input type="radio"/> Male <input type="radio"/> Female <b>Neck Circumference- Inches:</b>			
<b>Height- Feet:</b>	<b>Inches:</b>	<b>Weight:</b> <b>BMI:</b>			
<b>Have you been diagnosed or treated for any of the following conditions?</b>					
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Depression <input type="radio"/> Yes <input type="radio"/> No			
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Gastric Reflux <input type="radio"/> Yes <input type="radio"/> No			
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No			
Stroke	<input type="radio"/> Yes <input type="radio"/> No	C-PAP <input type="radio"/> Yes <input type="radio"/> No			
<b>Epworth Sleepiness Scale:</b> 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 have affected you. Use the following scale to check the most appropriate number for each situation. 0=never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing					
		0	1	2	3
Sitting and reading		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive, in a public place (theater, meeting, etc.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					<b>Score: _____</b>
<b>2. Do you wake up choking or gasping?</b>					
<input type="radio"/> Never <input type="radio"/> Rarely (>1/week) <input type="radio"/> Sometimes (1-2/week) <input type="radio"/> Frequently (3-4/week) <input type="radio"/> Almost Always (5-7/week)					
<b>3. Have you been told that you stop breathing in your sleep or wake up choking or gasping?</b>					
<input type="radio"/> Never <input type="radio"/> Rarely (>1/week) <input type="radio"/> Sometimes (1-2/week) <input type="radio"/> Frequently (3-4/week) <input type="radio"/> Almost Always (5-7/week)					

### FOR OFFICE USE ONLY

- You have a very Low or No Apparent risk of having a sleep disorder and we will review this annually.
- You have greater than a 50% probability of having a sleep disorder and we recommend a complimentary home sleep study.

Scoring: **1** (Snoring + >17men, >16 women; BMI >30; any one condition; Epworth >6) or **2-3** (Observed gasping or choking) = positive result.

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

Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. of record: \_\_\_\_\_