Sleep Apnea Dentists of New England

B. Gail Demko, DMD
Accredited Dental Sleep Medicine Office
Credentialed by the American Board of Dental Sleep Medicine

140 Merriam Street • Weston, MA 02493 • *Mail Address:* PO Box 606 • Weston, MA 02493
phone 617-964-4028 • fax 617-595-4591 | 617-467-4751 • www.SleepApneaDentist.com

Registration Form

Name:_____

Address:_____

City:_____State:_____Zip:_____

Telephone: home:_____work:_____

Cell Phone: _____E-mail Address:_____

Social Security Number:_____

Date of Birth: _____Marital status:_____

Employed by:_____

Medical Insurer:_____

Subscriber #: _____

Subscriber Name if other than patient:_____

Subscriber Date of Birth:_____

Relationship to Subscriber:_____

Secondary Medical Insurer:_____

Subscriber Name if other than patient:_____

Responsible Party: _____

Name of person who referred you to the practice:_____

Sleep Physician's name:

_____

Office address: _____

Office telephone: _____

Primary Care Physician: _____

Office address: _____

Date of last exam: _____Did you have braces? Yes: _____ No:_____

General Dentist:_____

Office address: _____

Date of last exam:_____

Have you had an over night sleep study? Yes: _____No:_____ If so, when?_____

Have you gained weight in the past year? Yes: ____No:____ If so, how much? _____

Have you used CPAP? Yes: _____ No: _____ How long?_____ Pressure level:_____

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If any, the reason for stopping: _____

Nightly: _____ 3-6 nights a week: _____ 1-3 nights a week:_____ rarely:_____

Have you had an evaluation with an ear/nose/throat specialist? Yes: _____ No: _____

Have you had any throat or nose surgery? Yes: _____ No:_____

Do you have daytime sleepiness? Yes: _____ No:_____

Is there a family history of snoring? Yes: _____ No:_____

How often do you awaken at night? _____

I hereby authorize payment be made directly to B. Gail Demko, DMD, PC, for services provided to me.

I allow the release of pertinent medical records to my insurance company and my other medical providers.

Signature of Patient:_____Date:_____

I understand it is my responsibility to obtain referrals PRIOR to my visit and that co-pays and deductibles are my contractual responsibility and payable at the time of my visit.

I am also responsible for all fees necessary to collect my bill.

Signature of Patient:_____Date:_____