Dr. William J. Twohig D.D.S
Patient Intake

Date: _____

Patient Name:_____ Date of Birth:_____

Gender: M / F Home Phone:_____ Cell:_____ Work:_____

Address:_____

City:_____ State:_____ Zip:_____

Height:_____ Weight:_____ Neck Size:_____BMI:_____

Primary Care Physician:_____ Phone Number:_____

Type of Medical Insurance: Medicare HMO PPO Tricare Other N/A

Name of Insurance:_____ Member ID #:_____

Group #: Insurance Phone #

Have you been Diagnoses with the following?

Obstructive Sleep Apnea: Yes / No

Loud Snoring: Yes / No **High Blood pressure:** Yes / No **Heart disease:** Yes / No **Stroke:** Yes / No

Diabetes: Yes / No **Thyroid:** Yes / No **Insomnia:** Yes/ No **Depression:** Yes / No **COPD:** Yes / No

Morning Headache: Yes / No **Restless Leg Syndrome:** Yes / No **Night time Urination:** Yes / No

Epworth Sleepiness Questionnaire

Use the following scale to choose the most appropriate # for your situation.

0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Sitting and reading	**0**	**1**	**2**	**3**
Sitting quietly in a public place	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting quietly after lunch w/o alcohol	**0**	**1**	**2**	**3**
As a passenger in a car not stopping to stretch	**0**	**1**	**2**	**3**
In a car while stopped in traffic for a few minutes	**0**	**1**	**2**	**3**
Laying down to rest in the afternoon	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**

_____ **Total Score**

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

welcome

PATIENT NUMBER

Patient's Name _____ (Last) _____ (First) _____ (Initial) _____ (Date of Birth)

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. Do you experience dry mouth? ..... YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? ..... YES NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. T1SDH

DENTAL HISTORY

William J Twohig DDS

Medical History

Patient Name: Birth Date: Date Created:

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?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	
Do you require pre-medication prior to your dental appointment?	Yes No	If yes	
Are you taking any medications, pills, or drugs? Please List Below:	Yes No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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:

X Date:_____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name	Middle Initial	Last Name

Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○
Height	Feet / Inches	**Neck Size**	Inches	
Date of Birth	Month / Day / Year	**ID Number**	Optional	

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	

Bed Partner Questionnaire

To be completed by the Patient's bed partner, without influence of the Patient. Please complete and have the Patient bring with them to their sleep study appointment.

Patient's Name: _____ Date: _____
Relationship to Patient: _____

Please estimate how many hours of sleep your bed partner gets:

Sleep Schedule:	Hours Each Night:	How Long does it take to fall asleep?	How long is your partner awake during the night?
Work Days:			
Days Off:			

Mark any positions your bed partner sleeps in: ☐ Back ☐ Side ☐ Stomach

Does your bed partner snore? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they snore, please mark the positions they snore in: ☐ Back ☐ Side ☐ Stomach

How loud is his/her snoring? ☐ 1 (Light) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Loud)

Does your bed partner do any of the following in his/her sleep? (Please mark all that apply)
☐ Gagging ☐ Choking ☐ Snorting ☐ Gasping ☐ Teeth Grinding ☐ Kicking their feet

	Never	Occasionally	Often	Unknown
Does you bed partner take naps during the day?				
Does your partner stop breathing in his/her sleep?				
Does your bed partner fall asleep when driving?				
Does he/she fall asleep without warning?				
Does your bed partner kick their legs while sleeping?				
Does your bed partner mumble, talk, or yell during sleep?				

Does your bed partner awaken during the night? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they awaken, how long does it take them to get back to sleep? Hrs: ____ Mins: ____ ☐ Unknown
Do you know why he/she awakens? ☐ Yes ☐ No If yes, Why? _____
_____

Is you bed partner restless during sleep? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
Describe what they do when restless: _____
_____
_____

How much stress does your bed partner currently have? ☐ 1 (Light) ☐ 2 ☐ 3(A Lot) ☐ Unknown

Please estimate your bed partner's risk of falling asleep or dozing off in the following situations, using the following scale: 0 = No chance 1= Slight chance 2= Moderate chance 3= High chance

Sitting and reading : ☐ 0 ☐ 1 ☐ 2 ☐ 3	Lying down to rest in the afternoon : ☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV : ☐ 0 ☐ 1 ☐ 2 ☐ 3	As a passenger in a car, for an hour, with no break : ☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting, inactive, in public (Theater, Meetings, Etc,) : ☐ 0 ☐ 1 ☐ 2 ☐ 3	Sitting quietly after lunch, without Alcohol: ☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone: ☐ 0 ☐ 1 ☐ 2 ☐ 3	In a car, stopped in traffic, for a few minutes: ☐ 0 ☐ 1 ☐ 2 ☐ 3

Has your bed partner's mood, memory, concentration, or personality deteriorated or changed?
☐ Yes ☐ No If yes, please explain: _____

_____

_____

Does your bed partner's sleep problems disrupt your sleep? ☐ Never ☐ Occasionally ☐ Often
Explain: _____

_____

Please use this space for any other information you would like to add.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this form.

Statement of Sleep Apnea Therapy/ CPAP Intolerance

William J Twohig D.D.S.

❑ **I have mild or moderate sleep apnea and per the American Academy of Sleep Medicine, CMS Guidelines and insurance policy, I would like to use oral appliance therapy as first line treatment.**

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

- ❑ Mask Leaks
- ❑ An Inability to get the Mask to Fit Properly
- ❑ Discomfort Caused by the Straps and Headgear
- ❑ Disturbed or Interrupted Sleep Caused by the Presence of the Device
- ❑ Noise From the Device Disturbing Sleep or Bed/Partner's Sleep
- ❑ CPAP Restricted Movements During Sleep
- ❑ Latex Allergy
- ❑ I develop sinus/ear/throat infection
- ❑ Claustrophobic Associations
- ❑ An Unconscious Need to Remove the CPAP Apparatus at Night
- ❑ I Would Like to Use Oral Appliance Therapy in Conjunction with CPAP Therapy to Reduce the CPAP Pressure.
- ❑ My Job/lifestyle prevent nightly use (Military, Truck Driver)
- ❑ Other_____

Because of my intolerance and inability for CAPA to effectively treat my condition, I wish to utilize and oral airway dilation appliance (E0486) to treat my obstructive sleep apnea.

Patient Signature: _____ Date: _____

Dr. William J Twohig DDS
PO Box 579
Weyauwega, WI 54983
Phone: (920)867-3101

Office & Financial Policies

Appointments

One of our team members will notify you of your scheduled appointment 2 weeks prior to the date via email or text message. To receive this type appointment reminder, you must provide a valid email address, cell phone number, or both. For those patients that would prefer a phone call reminder for their upcoming appointment you will be notified 1 week prior. No matter your preferred method of contact, **ALL** appointments must be confirmed either by replying to your email or text message notification or by calling our office to verbally confirm your scheduled date and time. If you have a conflict with a scheduled appointment or are unable to make it to your scheduled appointment you must call the office to notify our staff. We ask that you do **NOT** notify us by email or by replying to our automated confirmation service as we may not receive the message in time.

We understand that sometimes things happen that would prevent you from being able to keep your scheduled appointment. But please keep in mind that when scheduling your appointment, that specific time is reserved only for you. If you are unable to keep your scheduled appointment we ask that you please notify us 48 hours prior to so that we may offer that appointment time to another patient. **Short notice cancelations (less than 48 hours) or No Shows may result in a missed appointment charge that ranges in fees of $75 to $150.** There are few exceptions to this policy but we do understand sudden illnesses and unforeseen situations.

We ask that patients with scheduled appointments please arrive 10 minutes prior to your scheduled appointment time. For patients that will be visiting us for the first time we ask that you arrive 20 minutes prior to your scheduled appointment time as there are a few forms that, by law, need to be completed upon your arrival at the office. If you know that you will be running late for your appointment we encourage you to please call our office and inform us of the situation. We reserve the right to reschedule your appointment if we feel that the appointments of other patients will be affected.

Insurance & Financials

Our dental practice works with most dental insurance plans; however, we are a non-contracted provider and encourage our patients to please familiarize themselves with their insurance plan. As a courtesy to our patients we will submit your insurance claim but it is your responsibility to follow up regarding benefit payments. Because we are a non-contracted provider some insurance plans do send the benefit payment to the policy holder.

We ask that payments for any and all services be made the day of your appointment. If we are submitting to your insurance provider we do expect the patient portion to be paid at the time services are rendered. Services that will not be covered by your insurance plan must be paid for that same day as well. We accept cash, check, all major credit cards, Care Credit and Lending Club. If you are unfamiliar with Care Credit or Lending Club one of our helpful team members would be happy to help answer your questions. We do not offer in house payment plans or financing.

Patient Name: _____
(Please Print)

Patient Signature: _____
(Signature of Patient, Parent, or Guardian)

Date: _____

Dr. William J Twohig DDS
PO Box 579
Weyauwega, WI 54983
Phone: (920)867-3101
Fax: (920)867-3108
Email: info@drtwohig.com

Patient Authorization to Copy Records/X-rays for Sleep Evaluation

I, _____, hereby request and authorize
(*Patient and/or Guardian name, **please print***)

_____
(Current *practice or dentist name*)

to turn over my dental records to **Dr. William J. Twohig DDS**, for a sleep screening and evaluation.

By authorizing the transfer, I understand that I am not impairing

_____
(*Name of current dentist*)

right of access to my records, when necessary, during the time period in which I'm under his/ her care.

Sign: _____
(*Patient and/or Guardian signature*)

Date: _____

Email is our preferred method of transfer. Please send records to: info@drtwohig.com
-OR-
Dr. William J. Twohig
PO Box 579
Weyauwega, WI 54983