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PATIENT: _____

Concerns:

What Prompted You to Seek Diagnosis and Treatment? _____

Sleep Apnea Snoring Alternative to CPAP

Any Use of Oral Appliance for Tooth Grinding? Y N For Breathing? Y N

Jaw Joint Problems? None Pain Limitations: _____

Any Dental Treatment Recommended? _____

Other Dental Concerns: _____

Any Other Concerns: _____

History of Surgeries: _____

Marital Status: Married Single Divorced Partner

Children: _____

Alcohol Use: Yes No Drinks per day: _____

Smoker: Yes No

Past smoker quit date: _____

Family History: Health Issues

Mother: _____

Father: _____

Siblings: _____

Children: _____

Occupation: _____

In your own words why are you seeking treatment for Sleep Disordered Breathing?

Treatment Will Be Successful When: _____