DENTALSLEEPAPNEANY

Sleep Apnea and Snoring Treatment Center
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Oral Appliance Therapy and Sleep Study Order Form

Patient Information:

Name:_____Sex: _____DOB:_____SSN:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____

Insurance Demographics:

Payer name 1:_____ID#:_____Group #:_____

Payer name 2:_____ID#:_____Group #:_____

Referring Physician Information:

Physician Name:_____NPI:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Patient is Being Referred For: *(Must have at least one checked)*

____Oral Appliance Therapy (EO486) ____Consult and or Treatment ____Matrix

Sleep History & Physical *(Must have at least one checked)*

_____Sleep disordered breathing	____Loud snoring	____Excessive daytime somnolence
_____Observed apnea	____Morning headaches	____Awakening gasping for breath
_____Non-restorative sleep	____Morning dry mouth	____Depression

I am the patient's treating physician and I have filled out this prescription based upon a face to face office visit. I am ordering this therapy to treat my patient's OSA and/or snoring.

Physician Signature:_____**Date:**_____