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
____Observed apnea
____Non-restorative sleep
____Loud snoring
____Morning headaches
____Morning dry mouth
____Excessive daytime somnolence
____Awakening gasping for breath
____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:**______________________________