MATTHEWS FAMILY DENTISTRY

Snoring/ Obstructive Sleep Apnea/ Oral Appliance Referral Form

PLEASE COMPLETE AND FAX TO **704-708-9185**.

Provider Information

Referring Doctor: _____

Referral Date: _____

Doctor's Telephone #: _____

Doctor's Fax #: _____

Patient Information: *PLEASE FAX LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK) WITH REFERRAL*

Name: _____ DOB: ____/____ /____ MALE / FEMALE

Address: _____

_____

Patient's Preferred Phone #: _____Alternate Phone #: _____

Insurance Company:_____Policy #: _____

Group Number:_____Insurance Phone #: _____

Reason for Referral

☐ Primary Snoring ☐ Mild/Moderate OSA ☐ Severe OSA ☐ CPAP Intolerant ☐ Other _____

Referral Instructions (please check treatment requested)

☐ Consultation for Oral Appliance Therapy Only

☐ Oral Appliance Therapy

☐ Comprehensive Dental Evaluation

Physicians Signature: _____Date: _____

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