Dental Sleep Solutions of Greenville
4818 Wellington Street
Suite 3
Greenville, TX 75402
(P) 903-455-0516

Dental Sleep Solutions of McKinney
8751 Collin McKinney Pkwy
Suite 1502
McKinney, TX 75070
(P) 214-592-8042

Both offices - Fax # 903-455-5888 or Email to smithdentistry@protonmail.com

Prescription for Oral Sleep Appliance

Patient Name: ____
Patient Date of Birth: _____________________________________
Address: ____
Phone: ____
City, State, Zip: ____

Patient Signs & Symptoms

		Additional
___ Loud Snoring	___ Restless Sleep	
___ Witnessed Apneas	___ High Blood Pressure	___________________________
___ Daytime Drowsiness	___ Nighttime GERD	___________________________
___ Loss of Energy	___ Morning Headaches	___________________________

Patient referred to Dr. Kyle Smith to be evaluated for **oral appliance therapy (OAT)** due to:

___ The patient has been diagnosed with obstructive sleep apnea
___ CPAP Intolerance
___ Seeking Oral Appliance Therapy to manage mild, moderate, or severe OSA condition
___ Primary Snoring
___ Surgical Result Inadequate, seeking alternative
___ Interested in Oral Appliance Therapy to be used as adjunct to CPAP or Surgery
___ Additional comments regarding patient's history of OSA therapy:

____

____

Please check if you would like us to provide Home Sleep Study service, we provide HST via Watchpat. ______

If Sleep study data exists, please send it to our office prior to the consultation appointment.

Referring Provider: ____
City & Zip: _____________________________________ State __________
Office Phone: ___________________________

Provider Signature: ____Date: _______________