DENTAL SLEEP SOLUTIONS of Greenville & McKinney

SLEEP APNEA & SNORING TREATMENT

DR. KYLE M. SMITH

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www.SleepApneaDFW.net

Rx: Oral Appliance Therapy with a Customized, Titratable, Mandibular Advancement Device

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

Patient Signs & Symptoms

___ Loud Snoring	___ Restless/Poor Sleep	Additional
___ Witnessed Apneas	___ High Blood Pressure	_____
___ Daytime Drowsiness	___ Nighttime GERD	_____
___ Loss of Energy	___Sleep Bruxism	_____
___ Morning Headaches	___Gasping or Choking at night	_____

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 only to manage mild, moderate, or severe OSA condition
___ Primary Snoring
___ Surgical Result Inadequate, seeking therapy
___ Interested in Oral Appliance Therapy to be used as adjunct with CPAP or Surgery

Additional information regarding patient:

_____

_____***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. Thank you!

Referring Provider: _____

City & Zip: _____ State _____ Office Phone: _____

Provider Signature: _____Date: _____