



McKinney Location
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Suite 1502
McKinney, TX 75070
(Phone) 214-592-8042

Greenville Location
4818 Wellington Street
Suite 3
Greenville, TX 75402
(Phone) 903-455-0516

Please Fax or Email Prescription to:
Fax: 903-455-5888
Email: smithdentistry@protonmail.com

www.SleepApneaDFW.net

PRESCRIPTION FOR ORAL APPLIANCE THERAPY

Patient : Empress Ellis Date of Birth: 01/17/1969

Patient Phone Number: 214-317-3135

Patient Signs & Symptoms:

- | | |
|--|---|
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Nighttime GERD |
| <input type="checkbox"/> Restless/Poor Sleep | <input type="checkbox"/> Loss of Energy |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Sleep Bruxism |
| <input type="checkbox"/> Gasping or Choking at night | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Daytime Fatigue | |

Diagnosis

- The patient has been diagnosed with Obstructive Sleep Apnea, Adult/Pediatric G47.33 (mild moderate severe)
 Other: _____

Additional Information, if needed:

New Referring Providers Only, Practice and/or Provider Name: _____

Address: _____

City: _____ Zip: _____

Office Phone: _____ Fax: _____

This Prescription is for Oral Appliance Therapy, E0486 or K1027, if applicable.

Referring Provider Name: _____

Provider Signature: _____ **Date:** _____

Provider NPI # _____