Pre-Appointment Information

Date: _____

Patient Information:

Patient Name: _____ DOB _____

Primary Phone: _____ Cell or Home? Work _____

Address: _____

Email**:** _____

Referred By: _____

Snoring & Sleep Apnea Info:

Do you snore loudly? **Y or N**

Have you been previously diagnosed with Sleep Apnea? **Y or N**
If yes, date of Last Sleep Study: _____

Do you use a CPAP machine nightly? **Y or N**
Were you prescribed a CPAP machine but had difficulty using it? **Y or N**

Are you having any current dental treatment that will change your bite? **Y or N**
If yes, please explain: _____

_____

Insurance Information:

Carrier: _____ Group Number: _____

Providers Phone Number _____ ID Number: _____

Name of Subscriber: _____ DOB: _____

Relationship to patient: _____

Super Bill Sent _____ Entered In AMD _____ Appt. Scheduled _____

NOTES: