

Obstructive sleep apnea is a multidisciplinary disease. In order that we may fully communicate with the other doctors and dentists you have chosen, it is very **IMPORTANT** for your care that you please fill out the following:

PATIENT NAME: _____ DATE: _____

DOB: _____ MALE: _____ FEMALE: _____

Primary Care Physician: _____
Address: _____

Phone number: _____

Fax number: _____

Sleep Physician's Name: _____
Address: _____

Phone number: _____

Fax number: _____

General Dentist's Name: _____
Address: _____

Phone number: _____

Fax number: _____

Specialist's Name: _____
Address: _____

Phone number: _____

Fax number: _____

(FOR OFFICE USE ONLY)

Chief Complaint:	Dentistry:	Tongue Size: Sm Med Lrg XL
	Brux:	Soft Palate: Short Med Long XL Broad
Neck Size:	TMJ:	Uvula: None Short Med Long XL Thick
PAS	Crowns:	Palatopharyngeal (Crowded): No Mild Mod Sev
Hyoid:	Opening:	Midline:
Cephalometric:	Range:	Retrognathia:
High vault palate:	NAR:	Narrow arch development:
Weight loss:		Cervicofacial adipose tissue:
		Positional apnea:
		QOL: