THE iSLEEP DENTAL PROGRAM®

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Date _____

Patient Information

Name: _____

Phone #: _____

Alt. Phone #: _____

Email Address: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

D.O.B.: _____ **Gender ☐ Female ☐ Male**

Height: _____ **Weight:** _____

Medical Insurance Information

Primary Insurance: _____

ID #: _____

Type of Service Requested

☐ **Ambulatory-Home Sleep Test**
☐ **Sleep Test at the Sleep Lab**
☐ **Oral Appliance Efficacy Sleep Study**
Current Oral Appliance Setting _____ *mm*
☐ **Authorization and Billing Service**
__ *Sleep study attached*

Patient Referred for Evaluation of

☐ **Sleep Apnea G47.33**
☐ **Hypersomnia with Sleep Apnea G47.30**
☐ **Other** _____

Clinical Symptoms

☐ **Snoring** ☐ **Choking During Sleep**
☐ **Daytime Fatigue** ☐ **Hypertension**
☐ **Witness Apnea** ☐ **Obesity**
☐ **Un-refreshing Sleep** ☐ **Diabetes**

Primary care Physician

Name: _____

Phone #:_____

Referring Dentist Information

Physician: _____ **Signature:** _____

Specialty: _____ **NPI #:** _____

Phone #: _____ **Fax #:** _____

Email Address: _____