



Wake Forest
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SEND TO: info@ncdentalsleep.com

Date: _____

Dr. _____

Your patient _____ DOB _____ contacted our office concerning an Oral Sleep Appliance. This is the only form of treatment our office will be providing for your patient. For this treatment to be successful for this patient, we are requesting the following information:

1. Does the patient have **planned dental treatment**? Yes___ No___
2. Does the patient have **uncontrolled periodontal issues**? Yes___ No___
3. Is the patient being treated for **TMJ issues**? Yes___ No___
4. Please include **Current Radiographs** (Panorex and/or Bitewings)

These records will provide us updated information that will help us ensure the proper appliance and fit for the patient. If you have any questions regarding this request, please call our office at **(919) 615-1258**.

DDS Signature: _____

Date: _____