

Dental Office:

Office Address: _____

Phone: _____

Fax: _____

Homepage: _____

Email: _____

Physician Name: _____

Physician Address: _____

Patient Information
Name:
Date of birth:
Date of Insertion:

Dear _____

Your patient has been in our office and received his/her oral appliance to address his/her condition of Obstructive Sleep Apnea to complete the first phase of oral appliance therapy through our program.

Our program consists of a comprehensive examination, thorough records and impressions of the upper and lower arches to construct an oral appliance with close observation and frequent maintenance appointments.

Patient has reported subjective relief of symptoms, and was informed of the importance of post insertion sleep study with an oral appliance for efficacy.

Please contact the above named patient for a follow-up appointment and correspond any further recommendations to our practice.

Please fax all results of the post insertion PSG/HST to us

FAX No: _____

Sincerely yours,

Dental Office: XXXXXXXXXXXXXXXX

Office Address: XXXXXXXXXXXXXXXXXX
XXXXXXXX NY XXXXX

Phone: (XXX) XXX-XXXX

Fax: (XXX) XXX-XXXX

Homepage: https://XXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXX

Email: XXXXXXXXXXXX@ XXXX

Physician Name: Dr. XXX

Physician Address: XXXXXXXXXXXXXXXXXX
XXXXXXXX NY XXXXX

Patient Information	
Name:	XXXXXX, XXXXX
Date of birth:	DD/MM/YY
Date of Insertion:	DD/MM/YY

Dear Dr. XXX

Your patient has been in our office and received his/her oral appliance to address his/her condition of Obstructive Sleep Apnea to complete the first phase of oral appliance therapy through our program.

Our program consists of a comprehensive examination, thorough records and impressions of the upper and lower arches to construct an oral appliance with close observation and frequent maintenance appointments.

Patient has reported subjective relief of symptoms, and was informed of the importance of post insertion sleep study with an oral appliance for efficacy.

Please contact the above named patient for a follow-up appointment and correspond any further recommendations to our practice.

Please fax all results of the post insertion PSG/HST to us

FAX No: (XXX) XXX-XXXX

Sincerely yours,

XXXX XXXXX, DDS
XXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXX