New York FAMILY DENTAL ARTS

340 E 72nd ST
New York, NY 10021
Phone: 212-628-3300
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Web: http://nycsleepdental.com/contact/

Patient Information

Full Name: _____

Last *First* *MI*

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone:_(_____)_____ Email: _____

Physician Name: _____ Phone: _____

Insurance Provider: _____ HMO: ___ PPO: ___ POS: ____ EPO: ___ INDEM: ___ MCR: __ MCD:____

Policy Number: _____ Group Number: _____ Employer: _____

Insured: Self Child Other Medicare: YES NO Sleep Study Available: YES NO

Reason for Referral (Mark all that Apply)

Diagnosis:

○ Obstructive Sleep Apnea ○ Insomnia due to Sleep Apnea

○ Sleep Apnea/ Sleep Related Breathing Disorder ○ Hypersomnia due to sleep apnea ○ Other, Unspecified

Without Appliance (CPAP or Oral Appliance): Respiratory Disturbance Index (RDI): _____

Lowest Desaturation (SpO2): _____ Apnea Hypopnea Index (AHI): _____ Percentage of Time Below 90%: _____

Therapies Attempted: CPAP Intolerant: _____ Not a Good Candidate: _____ Surgery: YES NO

Successful CPAP Pressure: _____

Comments/Concerns: _____

Statement of Medical Necessity

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed tat an Oral Appliance is medically necessary. Oral Appliance Therapy is used as an alternative to surgery at this time and/or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____