Prescription For Orofacial Pain

THE SNORING & SLEEP APNEA CENTER

PRESCRIBING PROVIDER

Provider Name:_____ Provider NPI #: _____
Phone: _____ FAX:_____
Address: _____

PATIENT INFORMATION

Patient Name: _____ Patient DOB:_____
Phone:_____ Email:_____

TREATMENT CONCERN:

___ Sleep Concerns

Patient Has:
___ Past Known Sleep Apnea Treatments
___ Frequent Heavy Snoring
___ CPAP Intolerance
___ Repeated Awakenings During Sleep
___ Obstructive Sleep Apnea
Other Relevant Symptoms:
_____

___ TMD

Patient Has:
___ TMJ Pain
___ Headache
___ Neck, Shoulder, Back or Facial Pain
___ Grinding and/or Clicking
___ Jaw Popping and/or Clicking
___ Jaw Movement Disorder
___ Ringing, Stuffiness, or Pain in the Ear(s)
___ Jaw Locked
___ Open ___ Closed
___ History of
___ TMD Treatments
___ Trauma to the Head/Neck Region
___ Other Pain

Chief Complaint:

PLEASE SEND COPIES OF ALL RELEVANT RECORDS AND DOCUMENTATION
(i.e., Sleep Studies, X-rays)

PROVIDER SIGNATURE: _____ DATE: _____

Please Fax this completed form to 206.770.0182