SLEEP APNEA FORM

Name: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Preferred Contact Method(s): ☐ Email ☐ Home Phone ☐ Cell Phone

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Gender: ☐ Male ☐ Female ☐ Other _____

Reason(s) For Consult:

- ☐ Snoring
- ☐ Breathing pauses or choking episodes at night
- ☐ TMD Consultation
- ☐ Pediatric Sleep & Orthodontics
- ☐ CPAP non-compliance
- ☐ MATRx Plus testing

Other Conditions

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ History of recent weight gain
- ☐ Depression

Other Conditions, Additional Comments, and Patient History:

Email: info@hometowndental.ca Fax: 403-982-3099