To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist.

FAMILY PHYSICIAN

Name_____
Address_____
_____
Phone_____

DENTIST

Name_____
Address_____
_____
Phone_____

SLEEP SPECIALIST

Name_____
Address_____
_____
Phone_____

CARDIOLOGIST

Name_____
Address_____
_____
Phone_____

Initial

OTHER

Name_____
Address_____
_____
Phone_____

Please list current medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify that the above information is correct to the best of my knowledge.

PATIENT SIGNATURE _____

DATE_____