young dentistry
SMILE CARE

Dear Dr. _________________

Our mutual patient, __________________Date of birth ____________, is seeking treatment at our office for a sleep breathing disorder. This patient may be a candidate for oral appliance therapy to treat obstructive sleep apnea.

In order to consider this patient's eligibility for this sort of treatment, we need to know more about their oral health. Can you **please send us copies** of any bitewings taken within last 2 years and any FMS/Panorex taken in last 3 years.

As their general dentist, can also you please complete the form below and fax (905-873-4800) or email it (smile@youngdentistry.ca) to our office at your earliest convenience:

Please indicate:

Date of last recall appointment:	Typical Scaling/Cleaning frequency:		
Does the patient have periodontal disease? (circle)	**Yes**	**No**	
To what degree? (circle)	**Mild**	**Moderate**	**Severe**
In your opinion, is this being adequately managed? (circle)	**Yes**	**No**	
If not, please explain:			
Any pending restorative treatment? (circle)	**Yes**	**No**	
If so please describe:			
Any tooth restorations of questionable strength?	**Yes**	**No**	
If so please describe:			
Any history of TMD or bruxism? (circle)	**TMD**	**Bruxism**	**None**
If so, describe any treatment provided:			

Patient Signed ____ Date __________________________

Please fax or email the signed form to Young Dentistry – Fax (905) 873-4821, smile@youngdentistry.ca

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