DENTAL QUESTIONNAIRE

Patient: _____

Date: _____

Your health plan requires that certain criteria be met before they can approve an oral appliance.

Please have your dentist answer the questions below and then sign and stamp or print their name below in the designated area.

Does the above listed patient have any of the following:

1. Active periodontal disease or dental decay?	☐ Yes	☐ No
2. Insufficient number of teeth to fit an oral appliance?	☐ Yes	☐ No
3. Have active Temporomandibular Joint disorder?	☐ Yes	☐ No
4. Have any restriction in their mandibular opening?	☐ Yes	☐ No
5. Have any protrusion of their jaw line?	☐ Yes	☐ No

If any responses to the above questions were yes, your dentist must explain why they believe that medical insurance should still approve the patient to be treated with an oral appliance to treat their obstructive sleep apnea

_____

_____

_____

_____

X _____ _____

Dentist's Signature Date

_____

Name of Dentist