Sleep Apnea
& TMJ Therapy
of Southern New England

Dr. Robert S. Semco DMD, MS, D. ABDSM
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Dentist Recommendation for Oral Appliance Therapy

To: Dr. Robert S. Semco

Oral Appliance Referral for:

Patient Name: _____ DOB: _____

Address: _____ Telephone:

City, State, Zip: _____ (Home) _____

Email: _____ (Cell) _____

Reason for referral:

☐ Snoring ☐ Sleep Apnea ☐ Not tolerating CPAP

☐ Other (please explain): _____

X-Rays: (Please forward x-rays or any relevant patient information to info@SleepRI.com)

Date of last panoramic x-ray: _____

Date of last cephalometric x-ray: _____

Any dental treatment planned? (Please circle) Yes No

(If yes, please explain)

Comments: _____

_____

_____

_____

Referring Doctor: _____ Date: _____
(please print)

Phone: _____

Signature: _____