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info@smilesinthepinesdental.com

SMILES IN THE PINES
LEJLA STREETS, DMD

Diplomate, American Board of Dental Sleep Medicine
Center for Airway and Functional Dentistry

Patient Referral	
Patient Full Name:	
Address:	
Phone Number (Home):	
Phone Number (Cell)	
Email:	
Date of Birth:	

Brief History

__ Patient has OSA and is CPAP intolerant
__ Patient: Hx of Snoring
__ Patent: Hx of Bruxism
__ Ankyloglossia/Tethered Oral Tissue
__ Jaw Pain/Clicking
__ Orofacial Pain

Medical History:

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Diabetes
- ☐ GERD

Please email our office any radiographs taken (FMX, BW, CBCST) to info@smilesinthepinesdental.com

☐ Please call patient to schedule appointment

Referring Physician: _____ Phone: _____

Signature: _____

Date: _____