DENTAL SLEEP APNEA, SNORING
AND TMJ TREATMENT CENTER

Dr. Charles Schneider

Contact Information

Name: _____ Date _____

Gender: _____ M _____ F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work: ( ) _____

Birth date: _____ Social Security Number: _____

Employer: _____

Present Dentist: _____ Date of last visit: _____

Address: _____

City: _____ State: _____ Zip: _____

Work done: _____

Present Physician: _____ Date of Last Visit: _____

Address: _____

City: _____ State: _____ Zip: _____

Are you currently under the care of a physician? _____ Yes _____ No

If yes, for what reason? _____

Medical Insurance Company: _____

ID# _____ Group # _____

Records Release: I hereby authorize Dental Sleep Apnea, Snoring, and TMJ Treatment Center to release my information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patients Signature: _____ Date: _____

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