Snoring and Sleep Apnea Center
sleepapnea@windstream.net
763.262.7667 ph / 763.262.2345 fx / 866.262.7645

Patient Name:____

Date:____

HEALTH CARE PROVIDERS

Health Care Provider:
Medical Doctor
Name: __________________________________
Address: ________________________________
Phone Number: ___________________________
Specialty: _______________________________

Chiropractor:
Name: __________________________________
Address: ________________________________
Phone Number: ___________________________
Specialty:________________________________

Dentist:
Name:___________________________________
Address:_________________________________
Phone Number:____________________________
Specialty:________________________________

Other Health Care Provider:
Name:___________________________________
Address:_________________________________
Phone Number:____________________________
Specialty:_________________________________

Other Health Care Provider
Name:___________________________________
Address:_________________________________
Phone:___________________________________
Specialty:_________________________________

Other Health Care Provider:
Name:___________________________________
Address:_________________________________
Phone:___________________________________
Specialty:_________________________________