# Patient request for The Niemtzow Dry Mouth Treatment


**Your name** _____

**Your full address:**

_____

**Your contact telephone number:** _____ **mobile:**_____

**Your contact email address:** _____

**Do you know the cause of your Dry Mouth condition, if Yes please Explain here**

**How long have you had the condition** _____**Year's**_____**Month's**

**Would you like to be treated** **Home / Dental surgery / Office**

**Please provide treatment address** _____

_____

**If treatment is at your Dental Surgery have you notified your Dental surgeon and do they accept Your preference to be treated at their surgery** **yes / no**

**Please provide dates of when you would like to be treated**

_____**day**_____**month**_____**year**_____**time**

**Please note that only 2 treatments are required to attempt and succeed in the treatment that we offer and these treatments must be on consecutive days at the same time. Please also note the conditions of pre treatment protocol required prior to undertaking your treatment.**

**DO NOT send any payment at this point in time. We will first notify you of the availability of a practitioner on your selected date and thereafter your invoice will be issued for payment.**

**Please return this document to:**
The Dry Mouth Foundation. Monometer house. Rectory Grove, Leigh-on-Sea, Essex, SS9 2HN