|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **How can we help you?** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Name | | | | | | |  | | | | | | | | | | | DOB | | | | | | |  |
| Address | |  | | | | | | | | | | | | | | | | SSN | | | | | | |  |
| City, State, Zip | | | | | | |  | | | | | | | | | | | Gender | | | | | | | ⬜ Male ⬜ Female |
| Phone |  | | | | | | | | | | | | | | | | | Insurance | | | | | | | ⬜ Dental ⬜ Medical |
| Thank you for contacting Synergy Dental Solutions. Please complete the following form in  order to assist us in processing your medical and financial paperwork requirements.    Are you a new or current patient? ⬜ New ⬜ Current | | | | | | | | | | | | | | | | | | | | | | | | | |
| New Patients: Who can we thank for referring you? | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **What is your primary reason for seeking care at our office?** | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⬜ General Dentistry | | | | | | | | | | | | ⬜ GROW Therapy Program | | | | | | | ⬜ iSpa Therapy | | | | | | |
| ⬜ ALF Therapy | | | | | | | | | | | | ⬜ Sports Dentistry/iSports | | | | | | | ⬜ Craniofacial Pain | | | | | | |
| ⬜ TMD/Structural Dentistry | | | | | | | | | | | | ⬜ Headaches/Migraines | | | | | | | ⬜ Cosmetic Dentistry | | | | | | |
| ⬜ Snoring/Sleep Apnea | | | | | | | | | | | | ⬜ Clenching/Grinding | | | | | | | ⬜ Biologic/Whole\*istic dentistry | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnostics: ⬜ Heart Rate Variability­ ⬜ Bite evaluation (TScan) ⬜ Posture Mat Scan ⬜ Other \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have a referral form, X-rays, images or reports from your previous health care providers? ⬜ No ⬜ Yes | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full name: | | | | |  | | | | | | | | | | | | | DOB | | | |  | | | |
| Is this appointment for you or someone else? | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Relationship | | | | | |  | | | | | | | | | | | |  | | | | | | | |
| Patient’s name | | | | | |  | | | | | | | | | | | | DOB | | | |  | | | |
| Preferred contact | | | | | | | | | ⬜ Phone ⬜ Email ⬜ US Mail | | | | | | | | | Phone | | | |  | | | |
| Email Address | | | | | |  | | | | | | | | | | | | @ | | | | | | | |
| Home address | | | | | |  | | | | | | | | | | | | | | | | | |  | |
| Do you have any of the following symptoms or have been diagnosed with: | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⬜ Headaches | | | | | | | | | | | ⬜ Facial Pain | | | | | ⬜ Jaw Joint pain | | | | | | | ⬜ Neck Pain | | |
| ⬜ Migraines | | | | | | | | | | | ⬜ Sleep Apnea | | | | | ⬜ Snoring | | | | | | | | | |
| ⬜ Jaw joint clicking and popping/TMJD | | | | | | | | | | | | | | | | ⬜ Bruxism *(teeth clenching and grinding)* | | | | | | | | | |
| ⬜ Movement Disorders *(Tourette’s, cervical dystonia)* | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Insurance**  *Please include a copy of the front and back of your insurance card* | | | | | | | | | | | | | |  | | | **Secondary Insurance**  *Please include a copy of the front and back of your insurance card* | | | | | | | | |
| Ins Company | | | |  | | | | | | | | | |  | | | Ins Company | | |  | | | | | |
| Ins Phone | |  | | | | | | | | | | | |  | | | Ins Phone |  | | | | | | | |
| Ins ID # | |  | | | | | | | | | | | |  | | | Ins ID # |  | | | | | | | |
| Ins Group # | | |  | | | | | | | | | | |  | | | Ins Group # | |  | | | | | | |
| *Patient Relationship to Subscriber* | | | | | | | | | | | | | |  | | | *Patient Relationship to Subscriber* | | | | | | | | |
| ⬜ Self ⬜ Spouse ⬜ Child ⬜ Other | | | | | | | | | | | | | |  | | | ⬜ Self ⬜ Spouse ⬜ Child ⬜ Other | | | | | | | | |
| Subscriber Name | | | | | | | |  | | | | | |  | | | Subscriber Name | | | |  | | | | |
| Subscriber Date of Birth | | | | | | | | | |  | | | |  | | | Subscriber Date of Birth | | | | | | | |  |
|  | | | | | | | | | |  | | | |  | | |  | | | | | | | |  |