|  |
| --- |
| **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 |  |
|  |  |  |  |  |