|  |
| --- |
| **Referral Form****Please fax to 618.281.9734 or email to WeCare@WeAreSynergy.com** |
| Introducing |  | Date |  |
|  | Address |  |
|  | Home # |  | Cell # |  | Work # |  |
| DOB |  | SS# |  |
|  | Referring Physician  |  | NPI# |  |
|  | Office Address |  |
| Fax |  | Phone |  |
|  | Contact Name |  |
|  |  |  |  |  |  |
|  | **What is your primary reason for seeking care at our office?** |
| □ | SmileLase and BabyLase services | □ | Tongue tie therapies (surgical and non-surgical) |
| □ | Headaches/Migraines | □ | Temporomandiblar Joint Disorder (TMD) |
| □ | Snoring/Sleep Apnea/Airway Dentistry | □ | Craniofacial Pain |
| □ | Biologic/Wholistic Dentistry | □ | Clenching/Grinding/Bite Analysis |
| □ | Wholistic Orthodontics and ALF Therapy | □ | Sports Dentistry (Performance and Protection) |
|  | **Diagnostics:** |  |  |
| □ | Tongue Tie Evaluation | □ | GemPro/SleepImage Overnight Wellness Assessment |  |
| □ | Bite Evaluation (TScan) | □ | Heart Rate Variability |
|  |  |
| Do you have x-rays, images or reports that you will be sending on the patient’s behalf? □ No □ Yes  |
| If so, please describe: |  |
|  |  |
| How will you be sending this information? □ Email □ Mail □ Sending with Patient  |
|  |  |
| Please provide any information that you feel will assist in the evaluation and/or treatment of this patient: |
|  |  |
|  |  |
|  |  |  |  |
|  |  |  |  |
| Primary Dental Insurance |  |
| Secondary Dental Insurance |  |
| ***Please include copy of front and back of insurance cards.*** |