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| **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?** |
| □ | ALF Therapy | □ | Orthodontic consultation |
| □ | Headaches/Migraines/Craniofacial Pain | □ | TMD/Structural Dentistry |
| □ | Snoring/Sleep Apnea | □ | Myofunctional Assessment (Tongue Tie) |
| □ | Biologic/Whole\*istic Dentistry | □ | Clenching/Grinding/Bite Analysis |
| □ | GROW Therapy/Pediatric Guided Facial Growth | □ | Sports Dentistry (Performance and Protection) |
|  | **Diagnostics:** |  |  |
| □ | Bite 4 Balance Scan (Baropodometric Posture Mat) | □ | GemPro/SleepImage Overnight Wellness Screening Assessment |  |
| □ | Bite Evaluation (TScan) | □ | Heart Rate Variability |
|  □ | Global Dental/Medical (Rule in/Rule Out) Evaluation  |
| 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: |
|  |  |
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|  |  |  |  |
|  |  |  |  |
| Primary Insurance |  |
| Secondary Insurance |  |
| ***Please include copy of front and back of insurance cards.*** |
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