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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 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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|  | | **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: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| 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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