ORAL FACIAL SOLUTIONS

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PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____ DATE OF REFERRAL ____ / ____ / ____

PARENT / GUARDIAN *(if applicable)* _____

PATIENT PHONE (____) _____

EMAIL ADDRESS _____

REFERRING DR. _____

REFERRING DR. PHONE (____) _____

PLEASE EVALUATE THE FOLLOWING

- ❑ Tongue thrust swallowing pattern
- ❑ Mouth breathing
- ❑ Post-frenectomy care
- ❑ Open mouth rest posture
- ❑ Tongue-tie / restricted lingual frenum
- ❑ Thumb / finger sucking habit

OTHER CONCERNS NOTED

- ❑ TMJ disorder / pain / discomfort
- ❑ Adenoid / Tonsil hypertrophy
- ❑ Speech problems
- ❑ Headaches / clenching / grinding
- ❑ Sleep apnea / sleep disordered breathing / snoring
- ❑ Other _____

AIRWAY SCAN

- ❑ Has been emailed to Oral Facial Solutions
- ❑ Will be provided by the patient
- ❑ Not available

COMMENTS / ADDITIONAL INSTRUCTIONS

HEALTH HISTORY