SEATTLE SMILES DENTAL

1325 4th Avenue, Suite 1230
Seattle, Washington 98101
TEL: 206.624.1773
info@seattlesmilesdental.com
seattlesmilesdental.com

Jenny Nguyen DDS | Asmeret Tesfahun DDS

REFERRAL FORM FOR CHILD (OVER AGE 1) AND ADULT FRENECTOMY

Please return form to us by email

Today's date:_____ Examination date: _____

Referred from (provider): _____

Specialty/field: _____

Referral address: _____

_____

Referral phone number: _____

Referral email: _____

Patient's name: _____ DOB: _____

Parent(s) or guardian: _____

Patient address: _____

_____

Contact phone number and name: _____

Should we contact the patient? ☐ Yes ☐ No

Reason for referral (check all that apply):	Signs/symptoms noted (past or present):
☐ Evaluation and report only ☐ Evaluation and treatment as needed ☐ Lingual (tongue) frenectomy ☐ Labial (lip) frenectomy ☐ Maxillary ☐ Mandibular ☐ Buccal (cheek) frenectomy Location(s) (near tooth #s): _____ Family history of lip/tongue-tie? ☐ Yes ☐ No	☐ diastema ☐ TMJ disorder/pain/discomfort ☐ speech disorder/problems ☐ adenoid/tonsil hypertrophy ☐ sleep apnea/snoring/sleep disordered breathing ☐ headaches/migraines ☐ clenching/grinding of teeth ☐ head/neck tension/discomfort ☐ mouth breathing/open mouth resting posture ☐ periodontal recession ☐ trouble breastfeeding/bottle feeding ☐ acid reflux ☐ high palate ☐ retruded mandible or retrognathia (small jaw) ☐ tooth crowding

Additional notes or concerns: