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CHILD (OVER AGE 10) AND ADULT FRENECTOMY EVALUATION REQUEST FORM

Please return form to us by email (preferred) or fax

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 Has patient started myofunctional therapy exercises? If yes, what date did they begin? ☐ Yes ☐ No Date: _____ If patient has completed myofunctional therapy, are they ready for release? ☐ 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: