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Thank you for referring to Dr. Tim Herre, DDS

1 PROVIDER NAME:

2 PATIENT CONTACT:

Name:

Phone:

Email:

3 NOTES: (PATIENT HISTORY, SYMPTOMS, CONCERNS, ETC)

4 REASON FOR REFERRAL:

- TMJ
- Sleep Dentistry (*Sleep Appliances*)
- Facial Pain / Headaches
- Teeth Grinding / Abnormal Wear on Teeth
- Tethered Oral Tissue Evaluation
- Frenectomy Referral (*Lip, Tongue, Buccal*)
- Orofacial Myofunctional Therapy
- Invisalign / Orthodontics
- Early Interceptive Orthodontics (*Expansion, Healthy Start*)
- Holistic Dentistry/Amalgam Removal
- Bio Rejuvenation Dentistry
- Airway Evaluation
- Needs A New Dentist
- Jaw/Skeletal Expansion
- Other (*please explain*)

DATE:

SIGNATURE:

