WEST VIRGINIA OROFACIAL WELLNESS

MAGDALENA S. HOLZ, DDS, MSD

Providing Orofacial Wellness and Myofunctional Therapy Services

Patient Name _____
Parent Name _____
Phone/Email _____

Date of Referral _____
Referring Provider _____
Phone/Email _____

Reason(s) for Evaluation: Check all that apply

- ☐ Frenum Restriction(s):_____
- ☐ Frenectomy Planned/Completed
  Date/Location(s): _____
- ☐ Oral Habit Elimination
- ☐ Tongue Thrust
- ☐ Low Resting Tongue Posture
- ☐ Low Oral Muscle Tone
- ☐ Headaches/Migraines
- ☐ Orofacial Pain Unspecified
- ☐ TMJ Pain/Dysfunction
- ☐ Clenching and Grinding
- ☐ Orthodontics Planned
- ☐ Orthodontic Relapse
- ☐ Sleep Disordered Breathing
- ☐ Mouth Breathing
- ☐ Snoring
- ☐ Sleep Hygiene Support
- ☐ Oral Development Education
- ☐ Other: _____

Other Helpful Information: _____

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☐ Please Call To Discuss
Phone: _____

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LOCATED WITHIN THE NICHE WELLNESS