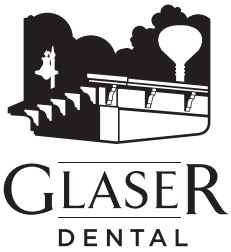
# Provider Referral Copy

**Fax the completed from to: 715.359.7733**




**Provider Name**_____

**Patient Information** *(Required)*

First Name_____Last Name_____

Patient Phone_____ Patient Email_____
*(000) 000-0000*

**Patient Notes –** Patient history, symptoms, concerns, etc

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**Reason for Referral**

- ☐ TMJ
- ☐ Sleep Dentistry
- ☐ Facial Pain/Headaches
- ☐ Teeth Grinding/Abnormal Wear
- ☐ Tethered Oral Tissue Evaluation
- ☐ Orofacial Myofunctional Therapy
- ☐ Second Opinion Conversation
- ☐ Airway Evaluation
- ☐ Needs a New Dentist
- ☐ Salivary Testing
- ☐ Periodontal Treatment
- ☐ Cone Beam 3D Imaging
- ☐ Other (Please Explain)

**Date**_____**Signature**_____
*(mm/dd/yyyy)*

Thank you!

FOR REFERRING TO DR. TYLER GLASER, DDS

**GLASER DENTAL**
24 Brown Boulevard, Rothschild, WI 54474
**Phone:** 715.359.4344 | **Fax:** 715.359.7733 | **Email:** smile@tylerglaserdental.com

# Referred Patient Copy

**Notes to Patient from Referring Provider**

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**GLASER DENTAL WEBSITE**

DR. GLASER LOOKS FORWARD TO MEETING YOU

*See you soon!*

**GLASER DENTAL**
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