



# BeRaediant- Dental Med Spa

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## REFERRAL FORM

	<b>Obstructive Sleep Apnea Consultation</b>
<input type="checkbox"/>	Restless Sleep
<input type="checkbox"/>	Mouth Breathing
<input type="checkbox"/>	Teeth Grinding
<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Trouble Concentrating / ADHD
<input type="checkbox"/>	Lip Tie / Tongue Tie
<input type="checkbox"/>	Chronic Ear / Sinus Infections
<input type="checkbox"/>	Inflammation of Adenoids and Tonsils
<input type="checkbox"/>	Crowded / Crooked Teeth
<input type="checkbox"/>	Bedwetting
<input type="checkbox"/>	Failed CPAP / CPAP Intolerant
<input type="checkbox"/>	Chronic Allergies

### Patient Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

### Referring Physician / Dentist:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_