Patient Information

Name:_____

Age:_____

Phone:_____

Email:_____

Orofacial Dysfunctions

- ◯ Tongue Tie
- ◯ Tongue Thrust
- ◯ Low Tongue Tone.
- ◯ Orthodontic Relapse.
- ◯ Thumb/Finger Sucking.
- ◯ Mouth Breating
- ◯ Clenching/Grinding
- ◯ TMJ/TMD
- ◯ Sleep Apnea/UARS
- ◯ Snoring
- ◯ Other _____
  _____

Referring Office

Doctor: _____

Phone: _____

Email: _____

Call or email Lori Eckhardt to schedule a 30 min consulation

buffalomyo.com
716 604-2818
Leckhardt@buffalomyo.com