



Annie Denning, BS, RDH

Orofacial Myologist

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent Name \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Doctor Signature \_\_\_\_\_

Comments \_\_\_\_\_

**Please evaluate and treat:**

- Mouth breathing (ICD-10-CM R06.5)
- Dysfunctional swallow (ICD-10-CM M26.50)
- Tongue-tie/restricted lingual frenum (ICD-10-CM Q38.1)
- Tooth crowding (ICD-10-CM M26.31)
- Digit sucking/oral habits (ICD-10-CM F98.8)
- Labial tie/restricted maxillary frenum

**Other concerns noted:**

- TMJ disorder/pain/discomfort (ICD-10-CM R68.84)
- Sleep apnea/snoring (ICD-10-CM R06.83)
- Clenching/grinding (ICD-10-CM F45.8)
- Sleep related bruxism (ICD-10-CM G47.63)
- Headaches (ICD-10-CM R51.9)

**ANNIE DENNING, RDH**

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