Referral Form
TMJ, Facial Pain, Headache & Sleep Apnea

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Improving Patients' Quality of Life Through Pain Management
Our Commitment to Your Patients, Reflects our Commitment to YOU!
Thank You for Referring Your Valued Patients to Our Care!

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Chief Complaint / Diagnosis: _____

_____

- ○ Evaluate and Treat
- ○ Specific Procedure Requests: _____

_____

_____

Please Evaluate:

- ○ Ear Pain
- ○ Facial Pain
- ○ TMJ Pain
- ○ Tooth Pain
- ○ Mouth Pain
- ○ Headache
- ○ TNJ Popping or Clicking
- ○ Burning Tongue
- ○ Movement Disorder
- ○ Locked Jaw

Patient Has::

- ○ Had TMJ Surgery
- ○ Had Full Dental Reconstruction
- ○ Nightguard or Splint
- ○ Had Jaw or Facial Surgery

Referring Physician or Dentist: _____

Phone: _____ Date: _____

Call for Location Information

Services Provided by an Arizona Licensed General Dentist

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