HEAD PAIN INSTITUTE

Referral Form

TMJ, FACIAL PAIN, HEADACHE & SLEEP APNEA

Patient Name _____

Email _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Chief Complaint / Diagnosis _____

_____

☐ Evaluate and Treat

☐ Specific Procedure Requests _____

_____

_____

Patient Has

- ☐ Had TMJ Surgery
- ☐ Had Full Dental Reconstruction
- ☐ Night Guard or Splint
- ☐ Had Jaw or Facial Surgery
- ☐ Had a Sleep Study
- ☐ CPAP Machine

Please Evaluate

- ☐ Ear Pain
- ☐ Facial Pain
- ☐ TMJ Pain
- ☐ Tooth Pain
- ☐ Headache
- ☐ TMJ Popping or Clicking
- ☐ Burning Tongue / Neuralgia
- ☐ Locked Jaw
- ☐ Sleep Disorder / Sleep Apnea

Referring Physician or Dentist _____

Phone _____ Date _____

Stan Farrell, DDS, FAAOP
Antonia Teruel, DMD, MS, PhD
Randy McDaniel, DMD, MS

www.headpaininstitute.com
p. 480.945.3629

9481 E. Ironwood Square Dr.
Scottsdale, AZ 85258

PLEASE FAX COPY TO 480.664.8972 OR
EMAIL COPY TO INFO@HEADPAININSTITUTE.COM

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!

Proudly Serving All of Arizona