



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 _____

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



www.headpaininstitute.com

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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!

Proudly Serving All of Arizona