Referral Form: Orofacial Pain, TMJ, Headache and Sleep Apnea

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Referring Physician or Dentist:_____

Phone:_____ **Date:** _____

Would you like a call: ☐ **Not necessary** ☐ **Before Evaluation** ☐ **After Evaluation**

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Email: _____

◯ Chief Complaint / Diagnosis:

_____

_____

◯ Evaluate and Treat

◯ Specific Procedure Requests:

_____

_____

Please Evaluate:

- ☐ Facial Pain
- ☐ Ear Pain
- ☐ TMJ Pain
- ☐ Dental / Tooth Pain
- ☐ Headache
- ☐ Locked / Stiff Jaw
- ☐ TMJ Popping or Clicking
- ☐ Limited Opening
- ☐ Other:_____

Patient has history of:

- ☐ TMJ Surgery
- ☐ Extensive Dental work
- ☐ Nightguard / Splint / Daysplint / Orthotic
- ☐ Facial or Jaw Surgery
- ☐ Trauma to Head or Neck
- ☐ Other: _____