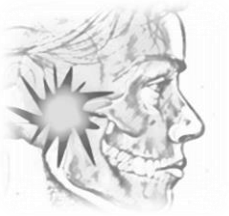

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TMD Referral Form

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Chief Complaint / Diagnosis: _____

❍ Evaluate and Treat

❍ Specific Procedure Requests: _____

Please evaluate:

❍ Headache ❍ Facial Pain
❍ TMJ Pain ❍ TMJ Locking
❍ TMJ Popping or Clicking
❍ _____

Patient Has:

❍ Had TMJ Surgery ❍ Nightguard or Splint
❍ Had Jaw or Facial Surgery ❍ Had MRI or CBCT of TMJ
❍ Had Full Dental Reconstruction
❍ _____

Referring Physician or Dentist: _____

Phone: _____ Email: _____Date: _____