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www.dallastmjdr.com

Patient's Name: _____

Date of Birth: _____

Contact Phone: _____

I am referring patient for the following symptoms (Please check all that apply)

- ☐ Obstructive Sleep Apnea
- ☐ Snoring
- ☐ TMJ Pain
- ☐ TMJ Noise (clicking/popping etc.)
- ☐ Locking Jaw (open or closed)
- ☐ Limited Opening
- ☐ Changes in Bite/Occlusion
- ☐ Chronic Head and Neck Pain
- ☐ Facial Pain
- ☐ Intra-oral Pain
- ☐ Unexplained Tooth Pain
- ☐ Headaches
- ☐ Earaches
- ☐ Other

I am specifically concerned about the following condition(s):

_____

_____

_____

_____

Name of Referring Doctor Signature

Phone: _____

PLEASE FAX/E-MAIL CONSULTATION REQUEST TO:

817 500-9672 / info@dallastmjdr.com