



Dr. Paul Grin, DDS, MPH, APC

South Bay TMJ, Sleep Headache & Orofacial Pain Institute

Orofacial Pain Specialist
Diplomate of American Board of Orofacial Pain
Fellow of American Academy of Orofacial Pain
Fellow of the American Headache Society

3475 Torrance Blvd. Suite. H | Torrance, CA 90503

P: 310.933.3077 | F: 310.982.2597

info@southbaytmj.com | www.southbaytmj.com

Patient Referral Form

Thank you for trusting us with the care of your patients.

Name: _____

Date: _____ Date of Birth: _____

Patients Ph #: _____ Cell #: _____

Email: _____

Patient's chief complaint, reason for referral: _____

Preliminary Assessment

Please check all that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Atypical Toothache | <input type="checkbox"/> PRP and Prolotherapy | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bruxism, Teeth Clenching | <input type="checkbox"/> Chronic Head & Neck Pain | <input type="checkbox"/> TMJ Pain / TMJ Noise |
| <input type="checkbox"/> Changes in Bite/Occlusion | <input type="checkbox"/> Muscle Spasm, Strain, Trigger Points | <input type="checkbox"/> Parasthesia, Dysesthesia Pain |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Locking Jaw |
| <input type="checkbox"/> Intra-oral Pain | <input type="checkbox"/> Snoring | <input type="checkbox"/> Limited Opening |
| <input type="checkbox"/> Burning Mouth Syndrome | <input type="checkbox"/> Oral Pathology and Biopsy | <input type="checkbox"/> Post Trauma Pain |

Other: _____

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

Referring Doctor's Name & Specialty

Phone #

Fax #

Email

Doctor's Signature

Please forward consultation request to: FAX: (310) 982-2597 or EMAIL: drgrin@southbaytmj.com