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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:

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