Dr. Eric Grin, DDS, MS, APC
Dr. Paul Grin, DDS, MPH, APC

South Bay TMJ, Sleep, Headache & Orofacial Pain Institute

Diplomate of American Board of Orofacial Pain
Fellow of American Academy of Orofacial Pain
3475 Torrance Blvd., Suite H | Torrance, CA 90503
P: 310.933.3077 | F: 310.982.2597
info@southbaytmj.com | www.southbaytmj.com

Physician Referral Form

Please complete this form, then FAX to (310) 982-2597 or EMAIL info@southbaytmj.com.

1. Referring Provider

REFERRING PROVIDER NAME

NPI #

CLINIC / PRACTICE

DATE

PHONE

FAX

EMAIL

2. Patient Information

PATIENT NAME

DATE OF BIRTH

PHONE

EMAIL

STREET ADDRESS

CITY

STATE

ZIP

PREFERRED CONTACT (PHONE / EMAIL)

3. Insurance

PRIMARY INSURANCE

MEMBER ID

GROUP #

SECONDARY INSURANCE (IF ANY)

4. Reason for Referral (check all that apply)

- ☐ TMJ / TMD (jaw pain, clicking, locking)
- ☐ Orofacial pain
- ☐ Headaches / migraines
- ☐ Trigeminal neuralgia / nerve pain
- ☐ Myofascial / muscle pain
- ☐ Obstructive sleep apnea / snoring
- ☐ Bruxism / teeth grinding
- ☐ Facial trauma / post-surgical pain

OTHER / ADDITIONAL DETAIL

5. Clinical Notes & Relevant History

REASON FOR REFERRAL, SYMPTOMS, DURATION, PRIOR TREATMENT

6. Records Attached (check all that apply)

- ☐ Clinical / progress notes
- ☐ Imaging (CT / MRI / X-ray)
- ☐ Sleep study results
- ☐ Copy of insurance card

7. Priority & Authorization

- ☐ Routine
- ☐ Urgent

Our team will verify benefits before scheduling.

REFERRING PROVIDER SIGNATURE

DATE