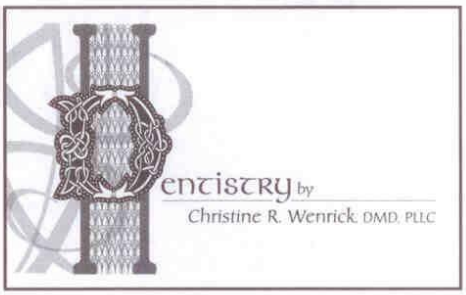
TMJ REFERRAL FORM



Patient Name: _____

Phone #: _____

Age: _____

Please check yes or no:

Past history of Orthodontic treatment?	❑ Yes	❑ No
Past history of Orthognathic surgery?	❑ Yes	❑ No
Past history of splint therapy?	❑ Yes	❑ No

Clicking/Crepitus TMJ?	❑ Yes	❑ No
Headaches?	❑ Yes	❑ No
Locked jaw?	❑ Yes	❑ No
Orofacial pain?	❑ Yes	❑ No
History of trauma?	❑ Yes	❑ No
Untreated dental disease?	❑ Yes	❑ No
Change in occlusion?	❑ Yes	❑ No
Bruxism habit?	❑ Yes	❑ No
Sleep disorder?	❑ Yes	❑ No
Sleep apnea?	❑ Yes	❑ No

Patient's Chief Complaint? _____

_____

Referring Doctor _____ Phone Number _____

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