RENO FACIAL PAIN & SLEEP GROUP

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Date: / /

PATIENT REFERRAL

PATIENT INFORMATION :

Patient's Name: .....

Patient's DOB: .....

Patient's Phone: .....

Patient's Email: .....

REFERRING DOCTOR'S INFORMATION:

Doctor's Name: .....

Doctor's Phone: .....

Doctor's Fax: .....

Doctor's Email: .....

Would you like a phone call? ◯ Not Necessary ◯ Before Consult ◯ After Consult

CONSULTATION FOR:

- ◯ TMJ Noises/ Dysfunction
- ◯ Jaw Pain
- ◯ Locked Jaw
- ◯ Persistent Tooth/ Oral Pain
- ◯ Bruxism
- ◯ Facial Pain
- ◯ Sleep Apnea/ Snoring
- ◯ Headache
- ◯ Dizziness/ Vertigo
- ◯ Ear Pain, Fullness, Muffled Hearing
- ◯ Difficulty Swallowing
- ◯ Neck/ Back Pain Stiffness
- ◯ Pain Behind Eyes
- ◯ Other (Please Explain Below)

COMMENTS:

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Please Send/ Attach the Most Recent Panoramic / Dental Radiographs if Available