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Orofacial Pain/TMJ Referral Form

Patient: _____ Date of Birth: _____

Patient Address: _____

Patient's email: _____

Medical Insurance Co. _____ ID: _____

Dental Insurance Co. _____ ID: _____

Referring Provider Name : _____

Provider's Phone: v:_____ f: _____

Please email X-rays, CT scans, or MRI or radiology reports to mydentist160@gmail.com

Brief Description of patient's signs and symptoms:

_____
_____
_____
_____
_____

Recommended information to be faxed with referral:

1. *Physician/dentist formal referral*
2. *Doctor's clinical notes*
3. *Patient demographics*
4. *Photo of patient's insurance cards, front and back*

_____ _____

Referring physician's signature *date*