



PATIENT INFORMATION

Patient: _____
Last First M.I.

Date of Birth: _____ Male Female

Phone: _____

Referring Doctor: _____ Date: _____

SIGNS & SYMPTOMS

Earaches, Fullness
or Ringing in Ears

Dizziness/Vertigo

Clicking or Grating
Sounds in TMJ

Locked Jaw

Pain or Soreness in TMJ

Headaches

Other: _____

Limited Mouth Opening

Teeth Grinding

SLEEP APNEA/SNORING

Evaluate for Oral Appliance Therapy (OAT)

Has patient had a Sleep Study? YES NO

Comments/Special Concerns: _____

Please forward any X-Rays, Sleep Studies, Images, and/or Notes

THANK YOU FOR YOUR REFERRAL!