



KEARNEY

COMPREHENSIVE DENTISTRY
TMJ & SLEEP THERAPY

TMJ THERAPY PATIENT REFERRAL FORM

Provider Information

Referring Doctor: _____ Referral Date: _____

Doctor's Telephone # _____

Patient Information: *Please email legible copy of insurance card (front & back) with referral.*

Name: _____ DOB: ___/___/___ MALE / FEMALE

Address: _____

Patient's Preferred Phone #: _____ Alternate Phone #: _____

CHIEF COMPLAINTS

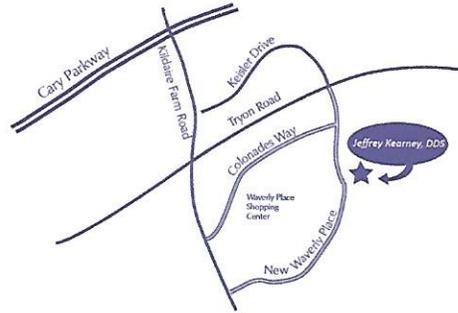
- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Joint Noise |
| <input type="checkbox"/> Earache, Stuffiness or Ringing | <input type="checkbox"/> Pain or Soreness in TMJ |
| <input type="checkbox"/> Limited Mouth Opening | <input type="checkbox"/> Jaw Locking (open or closed) |
| <input type="checkbox"/> Unexplained Tooth or Facial Pain | |

XRAYS:

- Being Mailed Given to Patient Please Take

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Diplomate American Board of Craniofacial Dental Sleep Medicine
Fellow American Academy of Craniofacial Pain