

David E. Peters, DDS, MS

TMJ Treatment Centers.com

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PATIENT REFERRAL SLIP

Patient Name:

Patient Concerns

<input type="checkbox"/>	TMJ Pain	<input type="checkbox"/>	Facial Pain	<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	TMJ clicking, locking	<input type="checkbox"/>	Ear Pain	<input type="checkbox"/>	Malocclusion
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Clenching/Bruxing	<input type="checkbox"/>	Other:

Referring Doctor Information

Doctor	
Address	
Phone	

Comments

<input type="checkbox"/>	I would like a phone call regarding this patient
<input type="checkbox"/>	Please send a letter/records re- garding my patient

Other Comments:

We respect your relationship with your patient and will continue to refer them back to your office during and/or at the completion of our treatment.