Non Surgical TMJ & Orofacial Pain Referral Form

Patient's Name:_____ Date: _____

Phone Number:_____ Date of Birth _____ ◯ Male ◯ Female

Patient's chief complaint: _____

Your concern: _____

_____

Current medications for this condition? _____

Past known TMJ treatments: _____

_____

X-Rays:

- ☐ Being mailed
- ☐ Given to patient
- ☐ Please take
- ☐ Mailed to info@alvaroordonezdds.com

Appointment Scheduling

- ☐ You want us to call the patient for an appointment
- ☐ Patient will call our office for an appointment

Do you have restorative plans for this patient? ☐ Yes ☐ No

Doctor's Name : _____ Phone: _____

Email: _____

Please FAX this form to: (305) 666-1431

Or email at info@alvaroordonezdds.com

Thank you.

ALVARO ORDONEZ, DDS
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