Houston TMJ
Facial Pain & Sleep

## PATIENT'S INFORMATION

Patient's name: _____

Patient's phone: _____ DOB: _____

Patient's e-mail: _____

### Reason for referral

- ◯ TMJ Pain
- ◯ Locking jaw
- ◯ TMJ Noise
- ◯ Facial Pain
- ◯ Bruxism, clenching, grinding
- ◯ Unexplained tooth pain
- ◯ Earaches
- ◯ Oral appliance for sleep apnea or snoring
- ◯ Burning mouth or tongue
- ◯ Headaches
- ◯ Neck or shoulder pain
- ◯ Dystonia
- ◯ Other

### Important notes

## REFERRING PROVIDER INFORMATION

Referring provider's name: _____

Phone: _____ Date: _____

Please fax form to 346-487-8216 or e-mail to:
contact@houstontmjdoctor.com

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contact@houstontmjdoctor.com
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