

TMJ & Headache Center

Phone: (440) 892-7773

Referral Form

Patient Name _____ Age _____

Referring Doctor _____ Date _____

Indications/Symptoms:

- | | |
|--|---|
| <input type="checkbox"/> Pain or soreness in TM joints | <input type="checkbox"/> Unexplained teeth or facial pain |
| <input type="checkbox"/> Clicking or grating sound in TM joint | <input type="checkbox"/> Limited mouth opening |
| <input type="checkbox"/> Locking jaw (opened or closed) | <input type="checkbox"/> Bruxism/Clenching |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Earaches, stuffiness or ringing |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sleep Apnea/Snoring |
| <input type="checkbox"/> Oral Appliance | <input type="checkbox"/> Other _____ |

Diagnostics/X-Ray/Testing:

- Complete Computerized Diagnostics (JVA, EMG, Jaw Tracker)
- w/X-Rays w/o X-Rays
- X-Rays
- CBCT (Cone Beam CT) Head X-Rays

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General Dentists

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TMJDoctor.net

How To Find Us.

