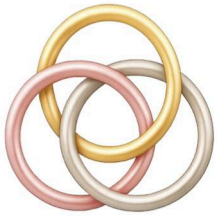

TRINITY
TMJ & FACIAL PAIN SPECIALISTS

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____

REASON FOR REFERRAL

- ☐ TMD/Jaw pain
- ☐ Facial Pain
- ☐ Trigeminal Neuralgia/Neuropathic pain
- ☐ Headache
- ☐ Sleep Apnea/Oral Appliance Therapy
- ☐ Pre-dental treatment check up
- ☐ Other: _____

Additional Information / Concerns:

_____

_____

REFERRING PROVIDER

Provider: _____

Practice: _____

Phone: _____ Fax: _____

☐ Relevant records / imaging attached

Please **ONLY FAX** this form and relevant records to: Trinity TMJ & Facial Pain Specialists

Fax: 972-674-1668 Phone: 972-677-3008

We will contact the patient directly to schedule an appointment.