



Referral Form

Referring Doctor: _____
Referring Doctor's Name: _____
Phone Number: _____
Email Address: _____

Patient Information: _____
Patient's Name: _____
Date of Birth: _____
Phone Number: _____
Diagnosis / Areas of Concern: _____

Please Evaluate For:

- TMJ Disorder or Orofacial Pain
- Sleep Apnea or Snoring
- Airway / Orthodontic Assessment
- Botox for TMJ, Pain, or Aesthetics
- Migraine Treatment. _____

Comments / Additional Information:



TMJ Relief 360 | 4320 Genesee Avenue,
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