# TMJ/Headache Patient Referral Form

**PATIENT'S NAME:**_____**DATE:**_____
**Phone number:** _____**Date of birth:**_____□ **Female** □ **Male**

**Patient's chief complaint:**_____
**Your concern:**_____
_____

**Current medications for this condition?** _____
**Past known TMJ treatments:** _____
_____

**X-rays:**
□ **Being mailed**
□ **given to patient**
□ **please take**
□ **e-mailed to: Renee@healthysleeptexas.com**
**Do you have restorative plans for this patient? □ Yes □ No**

**Appointment Scheduling**
□ **You want us to call the patient for an appointment**
□ **Patient will call our office for an appointment.**

**Doctor's name**: _____**Phone:**_____
**E-mail:** _____

## Please FAX this form to: 512-346-1372

**Thank you**