# Dr. Jason A. Megens, DMD

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## TMD/OROFACIAL PATIENT REFERRAL FORM

**Patient Name:** _____ **Date:** _____ ☐ Female

**Phone Number:** _____ **Date of Birth:** _____ ☐ Male

☐ Please contact patient ☐ Pt will contact your office ☐ Has appt on: _____

**I am referring our patient for the following symptoms** (please check all that apply)**:**

- ☐ TMJ Pain
- ☐ TMJ Noises
- ☐ Locking Jaw (Open or Close)
- ☐ Limited Opening
- ☐ Changes in Bite/Occlusion
- ☐ Headaches/Migraines
- ☐ Dizziness
- ☐ Ear pain, ringing or stuffiness
- ☐ Facial or undiagnosed teeth pain
- ☐ Neck or shoulder pain or stiffness

**I am specifically concerned about the following condition(s):**

_____

_____

_____

_____

**Doctor :** _____ **Date:** _____

**Phone Number:** _____ **Fax:** _____

☐ Exam ☐ 2nd Opinion ☐ Send Report ☐ Call Me

**PLEASE RETURN CONSULTATION REQUEST TO:**

**FAX: 254-774-8368**

**EMAIL: info@legacydentaltemple.com**