www.LunnDentistry.com

PATIENT REFERRAL

INTRODUCING: ____

APPOINTMENT DATE & TIME: ______________________________________

Please call 423-892-5137 to schedule your patient's appointment.

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

DATE:______________ REFERRING DR.____________________________________ PHONE:____________________________

This patient is being referred for evaluation of the following symptoms:

- ☐ Clicking or grating sounds in the jaw joints
- ☐ Congestion or stuffiness of the ears
- ☐ Cracking, chipping or breaking dental restorations
- ☐ Facial pain
- ☐ Limited movement or locking jaw
- ☐ Neck, shoulder or back pain
- ☐ Numbness
- ☐ Pain in teeth
- ☐ Pain or soreness around the jaw joints
- ☐ Unexplained loose teeth
- ☐ Worn, chipped or cracked teeth
- ☐ Other:___________________________

The patient has experienced the following:

- ☐ Dental extractions
- ☐ Facial trauma
- ☐ Orthodontic treatment
- ☐ Vehicular accident trauma
- ☐ Whiplash
- ☐ Other:___________________________

Comments:________________________
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❑ **Please call me for additional information.**

❑ **I have sent radiographs for your evaluation.**

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