Central New England Dental Associates

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PATIENT REFERRAL

Introducing:_____

Appointment Date & Time:_____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

Please call 508-832-5731 to schedule your patient's appointment.

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 in fingers and arms
- ☐ Pain in teeth that migrates
- ☐ Pain or soreness around the jaw joints
- ☐ Unexplained loose teeth
- ☐ Worn, chipped or cracked teeth
- ☐ Other:_____

The patient has experienced the following contributing factors:

- ☐ Dental Extractions
- ☐ Facial Trauma
- ☐ Orthodontic Treatment
- ☐ Vehicular Accident Trauma
- ☐ Whiplash
- ☐ Other:_____

*Comments:*_____

_____

☐ Please call me before proceeding with treatment. ☐ I have sent radiographs for your evaluation.

Referring Dr.:_____ Date:_____

Referring Dr. Phone #:_____