NATIONAL HARBOR OFFICE
301.839.0055

REFERRAL

BETHESDA OFFICE
301.652.3444

THE WASHINGTON TMJ & SLEEP THERAPY CENTER

Patient Name: _____ **DOB:** _____

For Evaluation of (check all that apply):

- ☐ Headaches
- ☐ Facial Pain
- ☐ Jaw Pain
- ☐ Jaw Locking
- ☐ Pain While Chewing
- ☐ Clicking/Popping of Jaw
- ☐ Neck/Shoulder Pain
- ☐ Snoring
- ☐ Sleep Disordered Breathing
- ☐ CPAP Intolerance

Other: _____

Pertinent Information: _____

_____

_____

_____

Referring Doctor:

Name: _____

Specialty: _____

Address: _____

Phone: _____

Signature: _____ **Date:** _____

A written detailed report will be mailed to the referring doctor upon evaluation of the patient.

For more information and office directions
please visit our website

WWW.DCTMJSLEEP.COM • INFO@DCTMJSLEEP.COM