Virginia Sleep & TMJ Therapy
VSTT
AT STONY POINT

Patient Referral for
TMJ / Orofacial Pain / Oral Medicine

Rebecca Angus DDS Alexander T. Vaughan DDS

Date: _____

Patient's Name: _____ Birth Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Reason for Referral: _____

_____

_____

Referring Physician Name: _____

Office Telephone: _____ Fax: _____

Contact Name: _____

Appointment Date/Time: _____

Images:

☐ Being Mailed Date: _____
☐ Given to the Patient Date: _____
☐ Please Take

Any other pertinent information: _____

_____

_____

If a H&P Containing this information is not available, Please check the following

☐ Clicking, Popping or Grinding sound in the TM joints
☐ Headaches
☐ Dizziness
☐ Pain or Stiffness in TM joints
☐ Migraines
☐ Limited Mouth Opening
☐ Locking Jaw (Open or Closed)
☐ Neck, Shoulder, Back Pain and Stiffness
☐ Earaches, Stuffiness or Ringing
☐ Deep Overbite or Retruded Mandible.
☐ Unexplained tooth pain or facial pain
☐ Anterior Open Bite

Appointment Scheduling:

☐ Please call Patient to schedule
☐ Patient will call your office to schedule

Appointment Follow Up:

Please: ☐ Call me after examination ☐ Send letter with findings ☐ Schedule 1:1 consultation with me

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It's time to get some rest.