# BeRaediant- Dental Med Spa

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## REFERRAL FORM

| | TMJ Consultation |
|---|---|
| ☐ | Grinding / Clenching Teeth |
| ☐ | Chronic Headaches / Neck Pain |
| ☐ | Chronic Shoulder / Back Pain |
| ☐ | Earaches without infection |
| ☐ | Dizziness / Vertigo |
| ☐ | Jaw pain / Clicking/ Popping jaw |
| ☐ | Fibromyalgia |
| ☐ | Trygeminal Neuralgia |
| ☐ | Other:_____ |

☐ Examination

☐ TMJ Orthotic Device

☐ Send Report

Patient Information:

Name:_____ DOB:_____

Phone:_____ Email:_____

Address:_____

Referring Physician / Dentist:

Name:_____

Phone:_____ Email:_____

Signature:_____