

Greg D. Larson, DDS, DABCP, DABDSM, DABCDMSM

Richard W. Van Gorp, DDS, DABDSM

Patient Name: _____ DOB: _____

Address: _____

Patient Phone #: _____ Email: _____

Call Patient to Schedule?

Referring Doctor: _____ Office Phone: _____

Location: _____ Fax: _____ Date of Referral: _____

Reason(s) for Referral:

TMJ

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Clicking, Popping or Grinding Sounds in TM Joints |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Locking Jaw (Open or Closed) |
| <input type="checkbox"/> Ear Pain, Stiffness or Ringing | <input type="checkbox"/> Unexplained Tooth Pain |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Numbness in Fingers or Arms |
| <input type="checkbox"/> Limited Mouth Opening | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain or Stiffness in TM Joints | |

Sleep Apnea

- Obstructive Sleep Apnea Diagnosed / Suspected (Circle One)
- Mild
- Moderate
- Severe
- CPAP Intolerant
- Snoring
- Upper Airway Resistance Syndrome (UARS)

Purpose of Consultation:

- Diagnose and treat patient as needed.
- Second Opinion (Please indicate current diagnosis / treatment)

Additional information on symptoms or special instructions:

Referring Doctor's Signature: _____ Date: _____

Thank You!

Charlotte Location: Belle Grove Office Park • 3111 Springbank Lane • Suite F • Charlotte, NC 28226

Concord Location: 1000 Copperfield Blvd. • Suite 154 • Concord, NC 28025

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