REFERRAL FOR DISORDERS OF TMJ/TMD

Date: ______________________

Patient Name: ______________________________
Phone: ________________________________
E-mail: ________________________________

This patient is being referred for evaluation of the following symptoms:

Clicking or grating sounds in the jaw joints
Facial Pain
Headaches/Migraines
Congestion or stuffiness in the ears
Limited movement or jaw locks
Neck, shoulder or back pain
Numbness
Cracking, chipping or breaking dental restorations
Ear Pain

Other: ____

Referring Dr: _________________________________
Office Phone: ____________________________
E-mail: _________________________________

Please e-mail or fax form to: 423.490.0791

We appreciate and thank you for your referral!

Riley H. Lunn, D.D.S., P.L.L.C.

5323 Brainerd Rd. Suite 106 / Chattanooga, TN 37411 / Phone: 423.892.5137 / Fax: 423.490.0791 / www.lunndentistry.com