



TMJ THERAPY & SLEEP CENTER
OF COLORADO

ROBERT B MCDONALD DMD

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Denver, CO 80222

303-691-0267

REFERRAL FORM

PATIENT INFORMATION

Last Name _____ First Name _____ DOB ____/____/____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ email _____

PRIMARY MEDICAL INSURANCE INFORMATION (not dental)

Name _____ ID# _____ Phone # _____

Subscriber _____ DOB ____/____/____ DOI ____/____/____

THIS PATIENT IS BEING REFERRED FOR: (Check all that apply)

- ☐ TMJ Dysfunction Evaluation and Treatment
- ☐ Obstructive Sleep Apnea Oral Orthotic Evaluation – please fax sleep study to 303-691-0268
- ☐ Orofacial Pain Evaluation and Treatment
- ☐ Movement Disorder Oral Orthotic Evaluation – Parkinson's, MS, Torticollis, etc.
- ☐ Other _____

RELEVANT MEDICAL HISTORY

Primary Symptoms _____

Diagnosis/Additional Information _____

REFERRING PHYSICIAN

Phone _____

Print Name _____ fax _____

Address _____ City _____ Zip _____

Signature _____ Date _____

Please fax this form to 303-691-0268 or email joan@drberrytmj.com

Thank you for your trust and confidence!