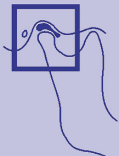

TMJ & Sleep Apnea Center

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Patient Name: ______________________________ Date : ________________

Date of Birth: _________ Chief Concern: ______________________________

Current Symptoms:

- ☐ Jaw pain ☐ Popping/clicking ☐ Headaches ☐ Earaches
- ☐ Reduced range of motion ☐ Locked jaw ☐ Change in bite
- ☐ Difficulty chewing ☐ Neck pain ☐ Facial pain ☐ Sleep apnea
- ☐ Other:

Referring Doctor: _______________________ Specialty: _________________

Office e-mail: _____________________________ Reports Preference

phone : _______________ fax: ______________ ☐ email ☐ fax ☐ mail