SAN FRANCISCO CENTER FOR TMJ AND SLEEP APNEA

GREG D. LARSON, DDS, FAACP, AGDF

Date: _____

Patient: _____ Patient Phone: _____
Patient Email: _____
Referred By: _____ Phone: _____
Email: _____

Reason for referral:
☐ TMD/Facial Pain
☐ Headaches/Migraine
☐ Sleep Apnea Diagnosed / Suspected (circle one)
☐ Upper Airway Resistance Syndrome (UARS)
☐ Snoring

Patient History:
☐ Nightguard
☐ CPAP
☐ Sleep Study
☐ CT Scan/MRI

How long in your practice: _____
Recent care in office: _____
_____
_____
_____
_____

Additional information on symptoms or special instructions:
_____
_____
_____
_____

THANK YOU FOR YOUR REFERRAL

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FELLOW, AMERICAN ACADEMY OF CRANIOFACIAL PAIN
PRACTICE LIMITED TO TMD | CRANIOFACIAL PAIN | SLEEP BREATHING DISORDERS