Practice Limited to Orofacial Pain

Center for Facial Pain
& Dental Sleep Medicine

Sherwin Arman, DMD

26800 Crown Valley Pkwy., Ste. 405, Mission Viejo, CA 92691

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3300 West Coast Highway, Newport Beach, CA 92663

Toll Free: (800) 357-2001 • Local: (949) 218-3516 • Fax: (949) 218-3534 • Email: info@drarman.com

www.drarman.com

Date: _____

Patient's Name: _____ Date of Birth: _____

Contact Phone: _____

I am referring patient for the following symptoms

Please check all that apply:

- ☐ Obstructive Sleep Apnea
- ☐ Snoring
- ☐ TMJ Pain
- ☐ TMJ Noise
- ☐ Locking Jaw (open or closed)
- ☐ Limited Opening
- ☐ Changes in Bite/Occlusion
- ☐ Chronic Head and Neck Pain
- ☐ Facial Pain
- ☐ Intra-oral Pain
- ☐ Headaches
- ☐ Earaches
- ☐ Other

I am specifically concerned about the following condition(s):

_____

_____

_____

_____

_____

Name of Referring Doctor Signature

Phone: _____

PLEASE FAX CONSULTATION REQUEST TO:
(949) 218-3534