

**SOUTH  
SOUND  
ORAL  
MEDICINE**

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Craniofacial  
Pain

TMJ/TMD

Atypical Facial  
Pain

Oral Mucosal  
Diseases

Taste & Smell  
Dysfunction

Salivary  
Abnormalities

Appliance  
Therapy for  
Sleep Apnea/  
Snoring

**Please Bring With You:**

- 1- This referral form
- 2- Oral appliance or nightguard if you have one
- 3- Information relating to medical and dental insurance

**Date:** \_\_/\_\_/\_\_

**Patient's Name:** \_\_\_\_\_

**Patient's Phone Number:** \_\_\_\_\_

**Referring Provider:** \_\_\_\_\_

**Referring Provider phone #:** \_\_\_\_\_

**Presenting complaint:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pertinent Medical Information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_