

SCREENING FORM

For patients with head, neck and facial pain
& sleep-disordered breathing/apnea

- Primary headaches or migraines
- Snoring/Sleep Apnea
- Disturbed, restless sleeping
- CPAP intolerance
- Attention deficit in children
- Earaches, stuffiness, ringing or dizziness
- Neck, shoulder, back pain or stiffness
- Pain or soreness in TM joints
- Clicking or grating sounds in TM joints
- Limited mouth opening
- Locking jaw (opened or closed)
- Chief complaint: _____

When your patients experience one or more of these symptoms, they should have a thorough evaluation by a dentist trained in TMD and Sleep. We will be happy to assist you in diagnosis and treatment for possible craniomandibular/temporomandibular dysfunction or sleep-disordered breathing/apnea.

Patient Information :

Name: _____

Address: _____

Phone: _____

Referred by:

Name: _____

Phone: _____

Date: _____ Fax: _____

__ Exam __ 2nd Opinion __ Send Report __ Call Me



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Instructions:

1. Mail or fax a copy to:
TMJ & Sleep Therapy Centre
2. Give a copy to the patient
3. Keep a copy for your files