CAROLINAS CENTER FOR
ORAL & FACIAL SURGERY
mycenters.com

TMJ Referral Form

Upon submission of the completed form, you will be given the opportunity to upload X-rays and print or save a copy of this form for your records.

Patient ______________________________ Date of Birth __________
FIRST NAME LAST NAME

Parents *(if minor)* ______________________________

Phone (Home) (   ) ______________ (Cell) (   ) ______________

Address ______________________________
STREET CITY STATE ZIP

Email ______________________________

TMJ Specialists

☐ **BILLINGSLEY RD.—CHARLOTTE**
☐ Erik F. Reitter, DDS

☐ **GREENVILLE/GREENWOOD**
☐ Mary Charles B. Haigler, DMD, MS

☐ **UNIVERSITY—CHARLOTTE**
☐ Erik F. Reitter, DDS

☐ **BLAKENEY/BALLANTYNE**
☐ John C. Nale, DMD, MD, FACS
☐ Erik F. Reitter, DDS

☐ **LAKE NORMAN/DENVER**
☐ Daniel R. Cook, DDS, MD
☐ Erik F. Reitter, DDS

TMJ Treatment Planning

Please evaluate for possible:

_______ Myofacial Pain

_______ Joint Noises

_______ Abnormal X-ray Findings

Facial Pain & Dysfunction

_______ Joint Pain/Pain on Function

_______ Closed Lock/Limited Mouth Opening

_______ Open Lock

_______ Headaches/Ear Pain

Additional Comments

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☐ Urgent

Referring Doctor ______________ Phone Number ______________ Date ________

2020