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AFFINITY
DENTAL ARTS

PATIENT NAME:	PHONE:	DATE:
REFERRING DOCTOR:	DOCTOR PHONE:	

◯ TMD ◯ AIRWAY

CHECK ALL THAT APPLY:

- ◯ HEADACHES / MIGRAINES
- ◯ FACIAL MUSCLE PAIN
- ◯ NECK PAIN
- ◯ SHOULDER PAIN
- ◯ UPPER BACK PAIN
- ◯ EARACHE PAIN
- ◯ CLICKING JOINT (R) (L)
- ◯ LIMITED OPENING
- ◯ UNABLE TO GET POSTERIOR TEETH TOGETHER
- ◯ CLENCHING / GRINDING
- ◯ TOOTH WEAR / FLATTENED TEETH
- ◯ TOOTH PAIN
- ◯ SNORING
- ◯ DIFFICULTY SLEEPING
- ◯ CHRONIC FATIGUE / TIREDNESS
- ◯ SLEEP STUDY OBTAINED BY PHYSICIAN
- ◯ CLOSED LOCK
- ◯ OPEN LOCK

TREATMENT PLAN:

COMMENTS:

SIGNED BY: