TMJ & OROFACIAL PAIN TREATMENT CENTERS OF WISCONSIN

It is very important to keep your doctors informed of your care. We would like to forward a copy of our report to them.

Please initial beside each doctor's name to allow us to send a report.

1. Referring Doctor: _____ _____ initial here to allow a report to be sent to this doctor
   Office name / Address: _____
   _____
   Phone: _____

2. Primary Doctor: _____ _____ initial here to allow a report to be sent to this doctor
   Office name / Address: _____
   _____
   Phone: _____

3. Primary Dentist: _____ _____ initial here to allow a report to be sent to this doctor
   Office name / Address: _____
   _____
   Phone: _____

4. Other Provider you are in care with: _____ _____ initial here to allow a report to be sent to this doctor
   Office name / Address: _____
   _____
   Phone: _____

5. Other Provider you are in care with:_____ _____ initial here to allow a report to be sent to this doctor
   Office name / Address: _____
   _____
   Phone: _____

6. Any other Physicians, Dentists, Chiropractors, Therapists or locations you would like a copy of a report sent to:
   Office name / Address: _____ _____ initial here to allow a report to be sent to this person
   _____
   Phone: _____

How did you hear about us?

Friend/Family Member: _____
Address: _____
Phone: _____

	Doctor listed in #1 above		One of our office staff/employees *
	Insurance book		Sign
	Newspaper		Magazine
	Radio		Television
	Healthwise publication		Coupon
	Yellow pages		
	Web / Internet		

Other: _____

*Name: _____ Phone #: _____

_____ _____
Signature Date

_____
Print Name

T-003 DS BW QP

Office Use Only: Initials_____ Location_____ Account#_____ Scanned_____