PROGRESSIVE IMPLANTOLOGY & PERIODONTICS

New Patient Information Line:
1.877.585.GUMS (4867)

www.RochesterPerio.com

Jeffrey M. Dolgos, DDS

TMD/OROFACIAL TREATMENT REFERRAL FORM

Name: ______________________________ Date: ______________

Appointment Date: ______________ Time: ______________ AM / PM

Referred by: ______________________________

SERVICES REQUESTED: (please check all that apply)

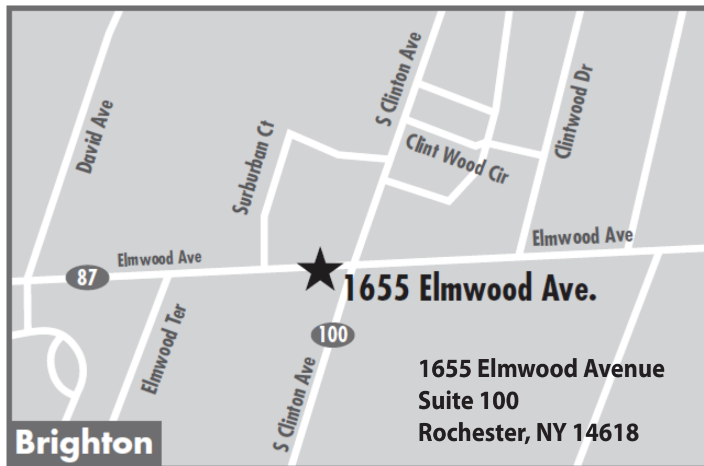
- ☐ Joint Noises
- ☐ Ear Pain, Ringing, Fullness
- ☐ Jaw Injury
- ☐ Headache
- ☐ Jaw Locking
- ☐ Sleep Apnea/Snoring
- ☐ Joint Pain
- ☐ Bite Problems

Remarks/Pertinent History: ______________________________

____

____

BRIGHTON OFFICE LOCATION:



For specific driving directions, please visit our website or call:
www.RochesterPerio.com | 585.319.4780

- All children under 18 years of age must be accompanied by a legal guardian for consultation and treatment.
- In the event you must cancel your appointment, please notify the office at least 72 hours in advance.

030915