MIAMI
ORAL & MAXILLOFACIAL SURGERY

JOSE I. MONTERO, D.D.S

TMJ Referral Form

Name: _____ Birth Date: _____

Referring Doctor: _____ Date:_____

Consult Indication (check all that apply):

- ☐ TMJ: _____
- ☐ Other: _____

Chief Complaint:

☐ Clicking ☐ Popping ☐ Crepitus ☐ Locking ☐ Dislocation ☐ Other: _____

Past Treatment(s):

☐ Orthotic ☐ Arthrocentesis ☐ Arthroplasty ☐ Arthroscopy ☐ Medications ☐ Other:_____

Imaging Available (to send):

- ☐ Panorex
- ☐ CBCT
- ☐ Photo

Case Notes:

_____

_____

8940 N. Kendall Drive, Suite 604E, Miami, Fl, 33176 I P: (305)595-1905 I F: (305)595-2219
www.miamioms.com I Email: miamioms@miamioms.com