INDIANA UNIVERSITY SCHOOL OF DENTISTRY
TMJ INSTITUTE

TMJ Patient Referral Form

To: **Dr. N. Shaun Matthews**

Today's Date: _____

Patient Name	DOB
Address	Primary Phone #
Patient Email	Insurance Information:

Reason for Referral *(Please forward applicable patient documents along with this referral.)*

History of Presenting Complaint:

Important Information for Referring Providers: Consultations with TMJ Institute faculty are reserved for patients that have exhausted all other conservative treatment options.

Please check the boxes below to confirm the patient has been treated with the following non-surgical approaches for their TMJ problem.

- ☐ Splint Therapy Date _____
- ☐ Physical Therapy Date _____
- ☐ Medication Date _____

Imaging:
Please indicate imaging procedures that have been performed prior to the date of referral.

- ☐ MRI Date _____
- ☐ CT/CBCT Date _____
- ☐ Panorex Date _____
- ☐ Other (list) Date _____

_____

Referring Provider	Referral NPI *(Required to Bill Medicare)*
Address	Referral Email
	Referral Phone #
	Referral Fax #

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