

TMJ TREATMENT RECORDS OF REQUEST

Patient Name: _____

Identification Number: _____

Date of Service: _____

SUBJECTIVE FINDINGS (*patients concerns*): _____

OBJECTIVE FINDINGS (*clinical examination findings*): _____

ASSESSMENT (*diagnosis*): _____

PLAN OF TREATMENT: _____

If you are prescribing an orthotic splint, please indicate the nature and purpose of splint: _____

In the case of your proposed surgery, please indicate conservative therapy that has been attempted: _____

If conservative therapy will not help this patient, identify the condition that supports your findings: _____

Name and address of referring physician: _____
