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| --- | --- |
| **Patient’s Name:** |  |
| **Patient’s Address:** |  |
| **Patient’s DOB:** |  |
| **Referring Doctor:** |  |
| **Referring Doctor’s Address:** |  |
| **Referring Doctor’s NPI# (Required for Insurance claims)** |  |
| **Referring Doctor’s Telephone#:** |  |

**Referral to the Center of Oral Medicine at the Dental College of Georgia**

Please check all that apply:

|  |  |
| --- | --- |
| * **Pre/Post Chemotherapy** | * **Pre/Post Radiation Therapy** |
| * **Oral Mucosal Lesions** | * **TMJ Disorder (TMD)** |
| * **Orofacial Facial Pain/Neuralgia** | * **Xerostomia/Dry Mouth** |
| * **Obstructive Sleep Apnea** | * **Biopsy** |
| * **Burning Mouth Disorder** | * **Halitosis** |
| * **Splint Therapy** | * **Pre/Post Chemotherapy/XRT** |
| * **Bisphosphonate-associated Jaw Necrosis** | * **Taste and Smell Disorders** |

Other:

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