|  |  |
| --- | --- |
| **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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|  |
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