



**TMJ & Sleep Therapy Centre
of Conejo Valley**

Screening/Referral Form

- Frequent snoring
- Sleep apnea
- CPAP Alternative
- Daytime fatigue
- Told that I "stop breathing" during sleep
- Headache/Migraine
- Ear Pain, Ear Stuffiness
- Tinnitus
- Pain behind the eyes
- Dizziness
- Limited mouth opening
- Neck, shoulder, back pain or stiffness
- Clicking or grating sounds to TM joint
- Pain or soreness in TM joint
- Locking jaw (opened or closed)
- Unexplained teeth or facial pain
- Numbness in fingers or arms
- Difficulty swallowing
- Athletic Protection/Performance Mouthware

Patient Information:

Name _____
 Address _____
 Phone _____

Instructions

- | | |
|----------------|--------------------------|
| Second opinion | <input type="checkbox"/> |
| Send a report | <input type="checkbox"/> |
| Examine | <input type="checkbox"/> |
| Call me | <input type="checkbox"/> |

Referred by:

Your name _____
 Signature _____ Date _____



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