



James Olsen, DDS

Cosmetic, Family & Neuromuscular Dentistry

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We are Referring:

Patient: _____ Patient Phone #: _____

Referred By:

Dr. _____ Date: _____

Dr. Phone number: _____

Chief Concerns:

- | | |
|--|---|
| <input type="checkbox"/> Clenching/Bruxing | <input type="checkbox"/> Broken Tooth |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Obstructive Sleep Apnea Appliance | <input type="checkbox"/> Supportive Care for Cancer Treatment |
| <input type="checkbox"/> TMJ Disorders | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> EMG Scans (K-7) | <input type="checkbox"/> Tooth Pain |
| <input type="checkbox"/> Cosmetic Dental Consult | <input type="checkbox"/> General Exam and Cleaning |
| <input type="checkbox"/> Full Mouth Restoration | <input type="checkbox"/> Other _____ |

Comments: _____

