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American Dental Association
Ohio Dental Association
Columbus Dental Society

Fellow Academy of General Dentistry
International Association for Orthodontics
American Academy of Cosmetic Dentistry
American Academy of Craniofacial Pain
American Academy of Dental Sleep Medicine

Patient Referral Form

Date _____

Referring Doctor:

Name _____

Telephone _____

This is to introduce: _____

Telephone: Home: _____

Work _____

Please Provide:

- ☐ Sleep Apnea Screening
- ☐ TMJ Tomographs (longitudinal, Cross Section)
- ☐ Implant Site Tomographs
- ☐ Panorex
- ☐ Lateral Skull (Ceph)
- ☐ Submentovertex
- ☐ AP Townes
- ☐ Paranasal
- ☐ Neuromuscular Screening