URBANEK
TMJ DEVICE & PROTOCOL

Registration for TMJ Disorders

Patient's Name: _____

Please provide us with all healthcare providers you have previously seen for the diagnosis or treatment of the symptoms you are currently experiencing, or any provider who has your medical/health records on file.

*** This information helps us communicate with your providers regarding your treatment. This will help providers understand proper diagnosis and decrease patients left misdiagnosed or untreated. We greatly appreciate your assistance. As much information as you have would be helpful!!

1. Dr's Name: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
2. Dr's Name: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
3. Dr's Name: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
4. Dr's Name: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____

**** Use Additional Forms if Necessary. Write on back if needed.**