Karyn Kahn, DDS
Parveez Rangwala, DDS
General Dentistry
Craniofacial Pain/Jaw Dysfunctions

Date:

Patient Name: Patient Phone Number:

Patient date of birth:

Referring Dentist: Dental Office Email:

☐ Comprehensive Temporomandibular Disorder Examination

☐ T.M.D. Evaluate and Treat

☐ Chief Complaint_____

☐ Previous Treatment_____

☐ Occlusal Orthotics_____

☐ Pharmacotherapy_____

☐ Imaging Avaliable/Date_____

☐ Additional Comments_____

- Please email any current radiographs including recent panorex and /or CT/MRI Imaging reports within the past five years to dentalimages@ccf.org. Please include the date that the x-rays were taken.

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