

OROFACIAL PAIN ASSOCIATES

of Colorado Springs

Introducing: _____

Date of Birth: _____ Phone: _____

Reason for Referral: _____

Referred by: _____ NPI# _____

Phone: _____ Fax: _____

Email: _____

Consultation Type:

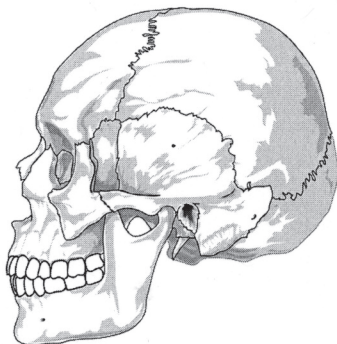
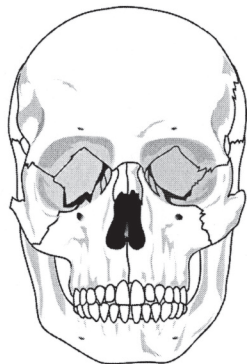
- Temporomandibular Joint Disorder
- Neuropathic Pain
- Orofacial Pain
- Oral Medicine
- Other

After Consultation/Evaluation Please:

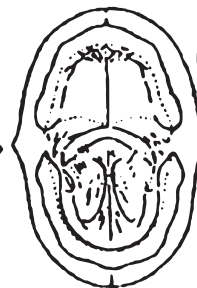
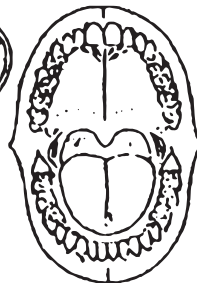
- Consult with me before proceeding with treatment.
- Proceed with treatment indicated

Enclosed:

- Clinical Photographs
- CBCT
- Brief Complaint/History
- Radiography
- MRI
- Other



RIGHT



LEFT