2525 W. Carefree Hwy., Bldg. 4 Suite 128 • Phoenix, AZ 85085
(623) 580-4600 • (623) 580-0977 FAX • **Airwayorthoaz.com**

Introducing: _____ Phone: _____

Parent/Guardian: _____ Date: _____

Reason for Referral: _____

_____

Please address the following:

❑ Mouth Breathing	❑ Sore or Painful Jaw	❑ Locking Jaw
❑ Dark Circles Under Eyes	❑ Sore Facial Muscles	❑ Clicking/Popping in Joint
❑ Disruptive Behavior	❑ Headache/Eye Pain	❑ Waking Unrefreshed
❑ ADHD Like Symptoms	❑ Ringing/Stuffiness/Fullness in Ears	❑ Tossing/Turning During Sleep
❑ Night Terrors	❑ Neck or Back Pain	❑ Loud Snoring

Referring Doctor: _____ Phone: _____

TMJ, SLEEP THERAPY
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