McDowell Dentistry
of Goodyear

*signature of excellence*

**George R. Ayoub, DDS, MS DICOI, MAAIP,FMI**
**Certificate Orofacial Pain**

**Phone** (623) 536-2040 **Fax** (623) 536-8555 **Email** office@mcdaz.com

**Patient Name:** _____

**Patient Phone:** _____

**Patient Email:** _____

**Patient DOB:** _____

## THIS PATIENT IS BEING REFERRED FOR:

- ◯ Jaw Pain / Popping
- ◯ Locking Jaw Limited Opening
- ◯ Ear Ringing
- ◯ Dizziness
- ◯ Frequent Headache
- ◯ Migraine
- ◯ Facial Pain
- ◯ Neck Pain
- ◯ Neuralgia / Neuropathic Pain
- ◯ Snoring / Sleep Disorder
- ◯ CPAP Alternative
- ◯ Oral Medicine

## SPECIFIC CONCERNS OR AREAS TO EVALUATE:

_____

_____

_____

## REFERRING DOCTOR INFORMATION:

**Name:** _____

**Phone:** _____

**Fax:** _____