MAHEC

COURTNEY R. JOHNSON, DDS

Oral Medicine Referral Form

Referred by: _____ Practice name: _____

Phone: _____ Fax: _____

Email: _____

Patient Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone: _____ Email: _____

Medical Insurance Company: _____ Policy #: _____

Dental Insurance Company: _____ Policy #: _____

REASON(S) FOR REFERRAL

- ☐ Oral Lesion/Biopsy
  - ☐ Lichen Planus
  - ☐ Dysplasia
  - ☐ Other
- ☐ Sjögren's Disease
  - ☐ Workup/Minor Salivary Gland Biopsy
- ☐ Medication -induced Hyposalivation
- ☐ Radiation -induced Hyposalivation
- ☐ Salivary Gland Disorders
- ☐ TMD
- ☐ Trigeminal Neuralgia / Neuropathy
- ☐ Atypical Facial Pain
- ☐ Burning Mouth
- ☐ Taste / Smell Disorders
- ☐ Halitosis
- ☐ Other _____

REMARKS

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