Edward D. Dallam, DDS
Healthy, Ageless Dentistry

Registration for TMJ Disorders

Patient's Name: _____

Please provide us with all healthcare providers you have previously seen; ANY provider who has your medical/health records on file.

This information helps us communicate with your providers regarding your treatment. This will help providers understand proper diagnosis and decrease patients left misdiagnosed or untreated. We greatly appreciate your assistance.

1. Name of Doctor/Provider: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
2. Name of Doctor/Provider: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
3. Name of Doctor/Provider: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
4. Name of Doctor/Provider: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
5. Name of Doctor/Provider: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
6. Name of Doctor/Provider: _____
   Name of Practice: _____
   Address of Practice: _____
   Phone Number: _____
   Office Email Address: _____
   ***Please let us know if you need additional forms to list Doctors/Providers**