ATLANTIS DENTAL
ORAL MEDICINE

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Diplomate, American Board of Oral Medicine
Certified Specialist in Oral Medicine

PATIENT REFERRAL

Date _____

Patient Name _____ **DOB:** _____

Daytime Phone: _____ **Email:** _____

Reason for Referral: (please check)

- **Mucosal lesion: leukoplakia, erythroplakia, lichen planus, mass, ulceration; other:** _____
- **Infection: Candidiasis, herpes, other** _____
- **Xerostomia, taste change**
- **Orofacial pain: burning sensation, neuropathic pain, neuralgia**
- **Headache / TMD: Describe:** _____
- **Injury (describe):** _____
- **Other, please explain:** _____

Related Medical History: _____

Referring Doctor's Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Dr. Joel Epstein Contact Information:

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