



Southern California  
**OROFACIAL PAIN**

BRYAN KIM, DDS

### PATIENT REFERRAL FORM

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_




Referring Doctor: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Referring Doctor Phone: \_\_\_\_\_ Patient Phone: \_\_\_\_\_


**REASON(S) FOR CONSULTATION:** Notes: \_\_\_\_\_  
(Check all that apply)

- Headache
- TMJ Issue
- Facial Pain
- Intraoral Pain
- Obstructive Sleep Apnea/Snoring
- Other: \_\_\_\_\_

**CONTACT US TODAY.**  
We'd love to work with you.

 (909) 517-0005  
 (909) 517-0006  
 info@scofp.com

 PLEASE FAX THIS FORM TO (909) 517-0006

 **Mission Viejo**  
26800 Crown Valley Parkway Suite 405  
Mission Viejo, CA 92691

 **Newport Beach**  
441 Old Newport Blvd  
Newport Beach, CA 92663

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