Patient Name: DOB:

Phone#: Email:

Referring Provider:

Referring Provider Contact fax:

Patient's Primary Dentist: Last Cleaning Date:

Preferred Location:

◯ Arlington ◯ Redmond Office

Alan Erickson DDS D.ABDSM Mohammad Khouzani DDS

Reason For Referral:

◯ Sleep Disorders ◯ TMJ Disorders

Additional Comments:

Providers, please submit referrals to:

F: 866-822-7148

E: Info@regensleeptmj.com

For emergencies CALL 360-322-6934 or 911

REGENERATIVE
SLEEP & TMJ