



Craniofacial Pain Relief Center

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Today's Date: _____

Complimentary 2nd Opinion

Thank you for considering us to help care for your patient.

This is intended for caregivers seeking a craniofacial pain point of view from Dr. Hart for a difficult case.

Referring Provider Name: _____ Phone: _____

Field of Practice: _____

Office Name: _____ Fax: _____

Office Address: _____ Email: _____

How did you hear about us? _____

Please email me the pertinent imaging a couple days in advance.

You are requesting a Google Meet video chat. Send the link to: _____



Patient Age: ____ Sex: M/F Gender: _____ BMI: ____ BP: ____ / ____ HR: ____ O2%: ____

Notable Medical/Dental History: _____

Medications: _____

Describe the problem: _____

How would you like me to help? _____

Thank You!

I look forward to speaking with you.