

Introducing: _____ Date of Birth: _____

Patient Ph. Number: _____ Patient Email: _____

Referring Office Name: _____ Referring Provider Name: _____

Referring Office / Provider Email: _____

Patient Diagnosis:

- myofascial pain
- degenerative joint disease
- bruxism
- _____

Treatment Goals:

- reduction in pain
- increased mobility
- prevention of pain or further injury
- management of chronic symptoms

Please list any other treatment modalities that have been a part of the patient's care
(custom night guard, orthotic, neuromodulators, etc)

- The patient will be scheduled for their first visit with the physical therapist, who will complete a detailed physical evaluation and review of their history
- Some treatment modalities may begin at this appointment, however the patient will be provided with a customized exercise and therapy program as well as hands-on education
- The following visits will consist of active therapeutic modalities and continual re-evaluations

Please provide any additional comments or concerns here.




online referral form

Dr. Shouvik Ponnusamy DMD, FACOMS (DR. SAMY)
Board Certified Oral and Maxillofacial Surgeon

Angela Seeger, PT
Doctor of Physical Therapy

15141 Ronald Reagan Blvd
Suite 516
Leander, TX 78641

512.881.8852
nivads.com
team@nivads.com

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team@nivads.com



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