

Oral Surgery Referral Form

Date: _____ Referring Dentist/Location: _____

Patient's Name: _____ Patient's Phone: _____

				A	B	C	D	E	F	G	H	I	J			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			

REASON FOR REFERRAL:

- Extraction
- Exposure
- Dental Implants
- Grafting Procedures
- Oral Pathology
- Other _____

Remarks: _____

NOTE: General anesthesia patients must abstain from food and liquids for at least 8 hours prior to appointment. They should be accompanied by an adult and not operate a motor vehicle.

Please bring this referral, a current medication list, and dental insurance information to your appointment. Contact our office for instructions on how to complete your registration and medical history prior to your appointment.