ADVANCED ORAL SURGERY

PATIENT REFERRAL

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Patient _____ DOB _____ SSN _____ TEL# _____

Insured's Name _____ DOB _____ SSN _____

Dental Insurance _____ Medical Insurance _____

Insurance Ph. # _____ Appointment Date & Time _____

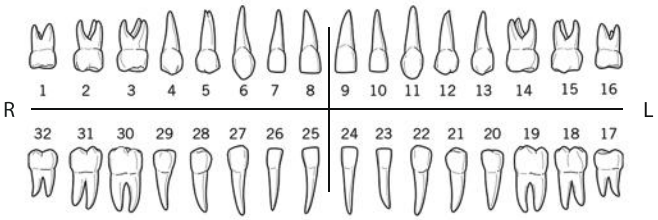
This patient is being referred for the evaluation of the following:

- ☐ Extraction Tooth# _____
- ☐ Wisdom Teeth# _____
- ☐ Bone Grafting# _____
- ☐ Expose and Bond# _____
- ☐ Propel # _____
- ☐ Other _____
- ☐ Apicoectomy Tooth# _____
- ☐ Infection
- ☐ Pathology
- ☐ Frenectomy
- ☐ TMJ
- ☐ Sleep Apnea
- ☐ Facial Fracture
- ☐ Trauma
- ☐ Orthognathic Sx
- ☐ Cosmetic Sx

Dental Implant Surgery:

☐ Implant # _____

(Please write and check a tooth)

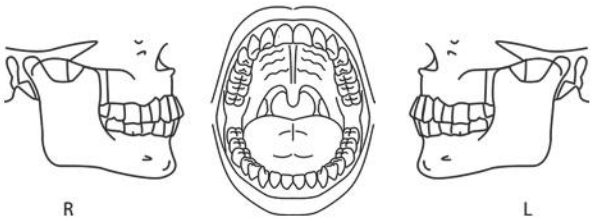


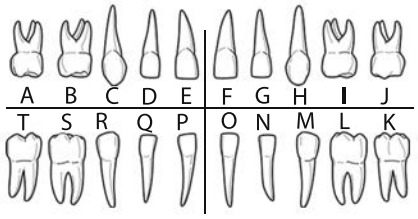
All on Four

- ☐ Maxilla
- ☐ Mandible

Abutment

- ☐ Cementable
- ☐ Screw Retained
- ☐ Custom
- ☐ Bridge





X-Rays:

- ☐ I have sent radiographs for your evaluation
- ☐ Please take necessary radiographs
  - ☐ Pano
  - ☐ Cone Beam CT
- ☐ Please call me before proceeding with treatment

Comments: _____

Referring Dr.: _____ Date: _____