OSS
Oral Surgery Solutions

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ORAL SURGERY REFERRAL

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PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Phone: _____

PLEASE EVALUATE FOR:

☐ EXTRACTION	☐ EXPOSURE	☐ ALVEOPLASTY
☐ IMPLANT	☐ BRACKET/CHAIN	☐ TORI
☐ BONE GRAFT	☐ FRENECTOMY	☐ LESION
☐ ALL-ON-X	☐ OTHER _____	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

COMMENTS: _____

_____

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_____

REFERRING DOCTOR: _____ Date: _____