# ORAL SURGERY REFERRAL

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## PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Phone: _____

## PLEASE EVALUATE FOR:

- ☐ EXTRACTION
- ☐ IMPLANT
- ☐ BONE GRAFT
- ☐ EXPOSURE
- ☐ ALL-ON-X
- ☐ FRENECTOMY

**Please note that we are only accepting the above referral types at this time.*

| 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: _____

_____

_____

_____

REFERRING DOCTOR: _____ Date: _____