AREA ORAL & MAXILLOFACIAL Surgery

Oral and Maxillofacial Surgery Referral Form

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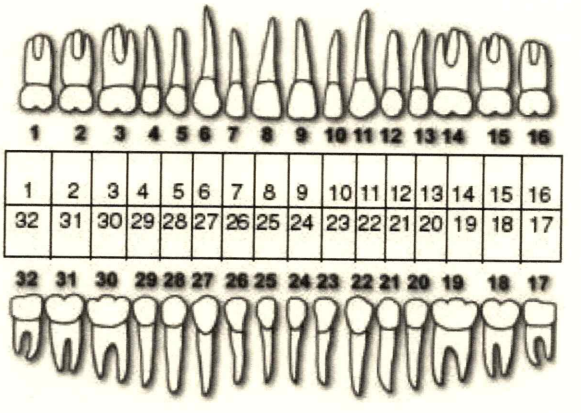
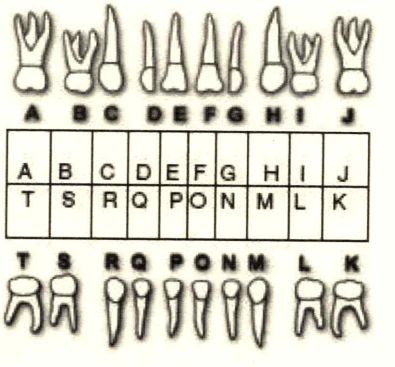
Date of referral: _____ Referred by: _____
Office phone/email/fax: _____
Patient name/parent (for minors): _____ DOB: _____
Patient phone: _____ Alternative phone: _____

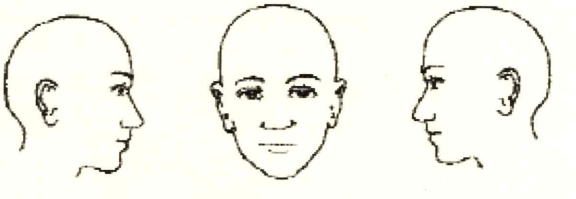
___ Consultation
___ Extractions
___ Dental Implants
___ Bone Grafting
___ Gingival Graft
___ Tori Removal/Aveoloplasty
(Pre-prosthetic Surgery)
___ Oral Pathology/Biopsy
___ TMJ Disorders
___ Surgical Exposure
___ Soft Tissue Augmentation
___ Other: _____



Radiographs:
___ Attached to this referral
___ Will send by email (info@areaos.com)
___ Will send by US mail
___ None available



Medical History:
___ Negative
___ Significant:
___ Special needs:



**Indicate facial injury, swelling, or other findings