FAX REFERRAL

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Phone: (830) 896-0056
Online registration: www.oralsurgerysatx.com

Referring: _____ _____ Date _____
Doctor's Signature

Patient_____DOB_____SSN_____-_____-_____

Address_____ Home #_____ Alternate #_____

Insured's Name _____ DOB _____ SSN_____-_____-_____

Dental Insurance _____ Phone #_____

Medical Insurance _____ Phone #_____

(Note: Medical Insurance is necessary for Trauma, Pathology & some Third Molar cases)

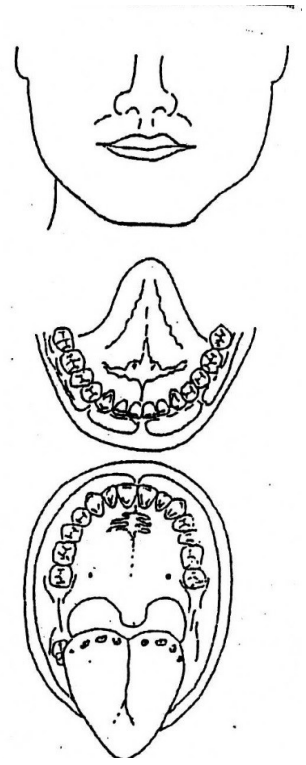
Reason For Referral

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	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			

____ Extractions #_____
(Please write in AND circle on the chart)

___ Implants (Teeth/Area) _____

___ Pathology (Indicate on drawing)
___ 3D Cone Beam CT Scan (reason) _____
___ Other Please Explain_____



I Am Sending:

___ Panorex ___ PAX Date taken: _____

___ Have your office take necessary radiographs

___ Emailed X-ray to: aos3@oralsurgerysatx.com

Appointment Status:

_____ An appointment was made by our office:
Date :_____**Time:**_____

Notes:

_____ _____

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****A REFERRAL MUST BE RECEIVED PRIOR TO A CONSULATION OR SURGERY** ..**