THE INSTITUTE OF
Jaw & Facial SURGERY

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PATIENT INFORMATION	
Date:	
First Name:	
Last Name:	
Telephone:	
REFERRING DOCTOR INFORMATION	
Referred By:	
Telephone:	
Email:	

EXTRACTIONS		
Right	☐ 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	Left
EXTRACTIONS		
Right	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J ☐ T ☐ S ☐ R ☐ Q ☐ P ☐ O ☐ N ☐ M ☐ L ☐ K	Left
Please Verify Teeth for Extraction:		

OTHER PROCEDURES
☐ Alveoloplasty
☐ Biopsy
☐ Incision and Drainage
☐ Lesion Evaluation
☐ Exposure
☐ Infection
☐ Expose and Bond
☐ Soft Tissue
☐ Frenectomy

CONSULTATION
☐ TMJ
☐ Implants
☐ Orthognathic Evaluation
☐ Pre-Prosthetic
☐ Cleft Lip and Palate
☐ Cosmetic
☐ Other:
IMPLANTS
SURGICAL TEMPLATE

RADIOGRAPHS OR CLINICAL PHOTOS
○ Being Mailed
○ Given to Patient
○ Please Take an X-Ray
TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM BELOW. AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.
COMMENTS