WILSON DENTAL

289 Chenango St
Binghamton, NY 13901
607-217-7123 607-238-1276(Fax) contact@wilsondentalny.com

GENERAL REFERRAL

Introducing: ____DOB: _______________________

Telephone: _____________________________________Insurance: _______________________________

Please circle the teeth or areas to be evaluated:

RIGHT **LEFT**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- ☐ Root Canal Therapy (No Retreats)
- ☐ Root Canal and Post and Core
- ☐ RCT/P&C/CROWN
- ☐ Crown (We do not do crown lengthening)
- ☐ Complete Dentures **Upper / Lower**
- ☐ Partial Dentures **Upper / Lower**
- ☐ Occlusal Guard
- ☐ Extractions
- ☐ Comprehensive care: Please diagnose and treat all current dental needs and ask the patient to return to our office afterwards
- ☐ Transfer of Care: Please allow the patient to make Wilson Dental his/her permanent dental home

Additional Comments:

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Referred by: ____

Referring office: ____

Signature: ____

Date: ____________________________Phone Number: _______________________________________