WILSON DENTAL

224 S. Geddes St.
Syracuse, NY 13204
(315) 423-9900 Fax (607) 238-1276

ORAL & MAXILLOFACIAL SURGERY REFERRAL

Introducing: ______________________ DOB: ______________________

Daytime Telephone: ______________________ Insurance : ______________________

Please circle the teeth or areas to be evaluated:

RIGHT		LEFT
A B C D E	F G H I J	
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	
T S R Q P	O N M L K	

____ Wisdom Teeth Removal
____ Extraction
____ Jawbone/Socket Preservation
____ Incision & Drainage
____ Expose & Bond
____ Other: ______________________

____ Pre-prosthetic Surgery
____ Periapical Surgery
____ Biopsy/Oral Medicine
____ I.V. Sedation/ Anesthesia

Radiographs
____ X-Rays needed
____ X-Rays given to patient
____ X-Rays emailed or sent
____ Send copies of X-Rays taken

Appointment Information:

Date: ______________________ Time: ______________________

Additional Comments: ______________________

____

Referred By: ______________________

Signature: ______________________

Date: ______________________ Phone Number: ______________________