WILSON DENTAL
224 South Geddes St
Syracuse, NY 13204
315-423-9900 607-238-1276(Fax) contact@wilsondentalny.com

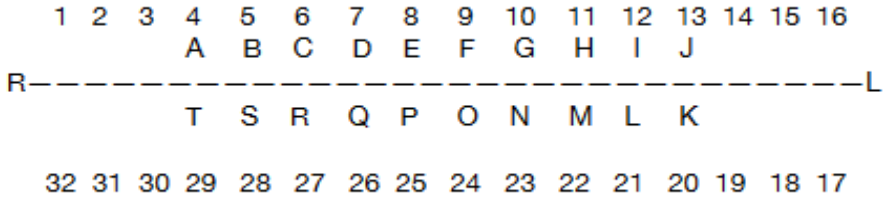
ORAL AND MAXILLOFACIAL SURGERY REFERRAL

Introducing: _____DOB: _____

Telephone: _____Insurance: _____

Please circle the teeth or areas to be evaluated:

RIGHT **LEFT**



- ☐ Wisdom Teeth Removal
- ☐ Extraction
- ☐ Jawbone/Socket Preservation
- ☐ Incision & Drainage
- ☐ Exposure and Bond
- ☐ Pre-Prosthetic Surgery
- ☐ Alveo/Bone Grafting
- ☐ Biopsy/Oral Medicine
- ☐ I.V Sedation/Anesthesia
- ☐ Dental Implant

Additional Comments:

_____

_____

_____

Referred by: _____

Referring office: _____

Signature: _____

Date: _____Phone Number: _____