

PATIENT INFORMATION:

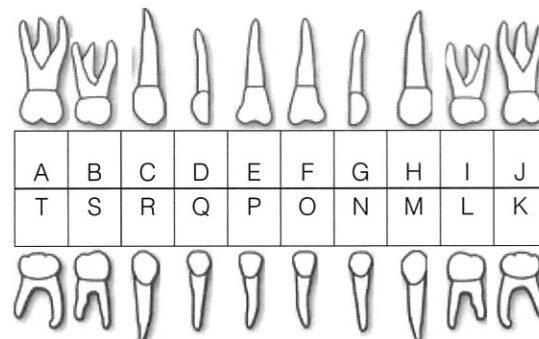
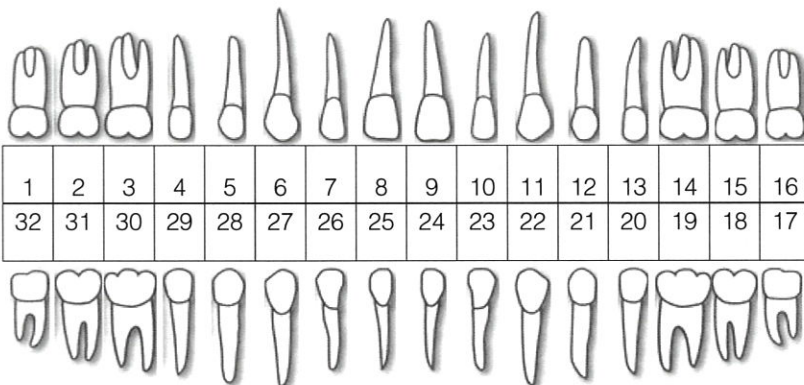
Today's Date _____ INSURANCE INFO: _____
 First Name _____ Last Name _____ Date of Birth _____
 Parent / Guardian Name _____
 Contact Telephone _____ Contact E-Mail Address _____
 Does the patient require antibiotics prior to dental treatment? Yes No • Patient will call for appointment Please call patient
 Treatment _____

REFERRING DOCTOR'S INFORMATION:

Referred By _____ Telephone _____
 E-Mail Address _____

PROCEDURES:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Extraction (see below) | <input type="checkbox"/> Exposure | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> Hard Tissue | <input type="checkbox"/> Apicoectomy |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Infection | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> Expose & Bond | _____ |
| <input type="checkbox"/> Lesion Evaluation | <input type="checkbox"/> Soft Tissue | _____ |



Please Verify Teeth For Extraction _____

CONSULTATIONS:

- | | | |
|--|---|--|
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Cleft Lip & Palate | <input type="checkbox"/> Bone Grafting |
| <input type="checkbox"/> Implants: <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed | <input type="checkbox"/> Cosmetic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Orthognathic Evaluation | <input type="checkbox"/> Ridge Augmentation | _____ |
| <input type="checkbox"/> Pre-Prosthetic | <input type="checkbox"/> Oral / Facial Lesion | _____ |

Implants:

Surgical Template:

RADIOGRAPHS OR CLINICAL PHOTOS:

- Being Mailed
 Given To Patient
 Please Take
 No X-Ray
 Attached With This Referral; if X-Rays are attached, what date were they taken _____

PLEASE EMAIL X-RAYS TO INFO@SLORALSURGERY.COM PRIOR TO PATIENT APPOINTMENT.

CASE NOTES: