REFERRAL FORM

Advanced
Oral & Facial Specialists

Date: _____

Patient Name: _____

Referred By: _____

Please circle affected tooth or area:

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

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

Check Treatment Requested:

- ☐ 3D Imaging
- ☐ IV Sedation/Anesthesia
- ☐ Dental Implants
- ☐ Bone Grafting
- ☐ Wisdom Teeth Removal
- ☐ Exposure of Impacted Teeth
- ☐ Dental Extractions
- ☐ Pre-Prosthetic Surgery
- ☐ Oral and Facial Trauma Management
- ☐ Facial Cosmetics
- ☐ Oral & Facial Infections Management
- ☐ Oral Pathology & Biopsy
- ☐ TMD Evaluation & Management

Notes: