WILSON DENTAL

728 E. Ridge Road
Rochester, NY 14621
(585) 491-7800 Fax (607) 238-1276

ORAL & MAXILLOFACIAL SURGERY REFERRAL

Introducing: _____

Daytime Telephone: _____

Please circle the teeth or areas to be evaluated:

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