



WILSON DENTAL

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

ORAL & MAXILLOFACIAL SURGERY REFERRAL

Introducing: _____

Daytime Telephone: _____

Please circle the teeth or areas to be evaluated:

RIGHT	A B C D E	F G H I J	LEFT
	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	

- | | |
|--|--|
| <input type="checkbox"/> Wisdom Teeth Removal | <input type="checkbox"/> Pre-prosthetic Surgery |
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Periapical Surgery |
| <input type="checkbox"/> Jawbone/Socket Preservation | <input type="checkbox"/> Biopsy/Oral Medicine |
| <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> I.V. Sedation/ Anesthesia |
| <input type="checkbox"/> Expose & Bond | |
| <input type="checkbox"/> Other: _____ | |

Radiographs

- | | |
|--|--|
| <input type="checkbox"/> X-Rays needed | <input type="checkbox"/> X-Rays emailed or sent |
| <input type="checkbox"/> X-Rays given to patient | <input type="checkbox"/> Send copies of X-Rays taken |

Appointment Information:

Date: _____ Time: _____

Additional Comments: _____

Referred By: _____

Signature: _____

Date: _____ Phone Number: _____