

ORAL SURGERY REFERRAL FORM

Patient Name: _____

Phone No: _____

Referring Doctor Name: _____

Phone No: _____

Address: _____

Appointment Location

Shamokin Dam — 30 Baldwin Blvd, Suite 95, Shamokin Dam PA 17876

Chambersburg — 1061 Lincoln Way E, Chambersburg PA 17201

Reason for Referral

Surgical Removal of Erupted Tooth

Bone Graft

Soft Tissue Impaction Tooth # _____

Implants

Partial Bony Impaction Tooth # _____

Biopsy

Full Bony Impaction Tooth # _____

Frenectomy

Surgical Removal of Root Tip

Alveoplasty

Removal of Tori UR UL LR LL

Consultation for Cosmetic Surgery

Teeth to be Extracted

PATIENT'S
RIGHT

PATIENT'S
LEFT

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

Clinical Information

Does Patient Require Premedication?

Yes No

Antibiotics Used: _____

Any Medical Concerns Requiring Attention: _____

Radiographs

Please take / send copy

Patient will bring copy

I will send / Please return

Referring Dentist's Recommendation

Referring Doctor Signature: _____

Date: _____

● Shamokin Dam

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● Chambersburg

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