

## Referral

Please complete this form and fax it to 909.469.8650. Please contact The Dental Center for an appointment at 909.706.3910. We must have this form BEFORE we can schedule an appointment. The cost of the initial appointment \$ 7.00.

PATIENT INFORMATION

Patient's Name *(Please print)* \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Patient Primary Telephone/Mobile Number \_\_\_\_\_

Other Telephone/Mobile Number \_\_\_\_\_

REFERRING DOCTOR

Doctor's Name *(Please print)* \_\_\_\_\_

Practice Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

### RADIOGRAPHS AND CLINICAL PHOTOGRAPHS

New radiographs may need to be taken at appointment.

Radiographs sent with patient      Clinical photos sent with patient

### RELEVANT CLINICAL INFORMATION

### DENTAL EXTRACTIONS

Please indicate which teeth are to be extracted: \_\_\_\_\_

Please place an "X" over the teeth you wish to have extracted.

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

#### DOCTOR SIGNATURE, DATE AND FAX REQUIRED

Dr. \_\_\_\_\_

Date: \_\_\_\_\_

Fax: \_\_\_\_\_

### OTHER SURGICAL PROCEDURES

Alveoloplasty      Biopsy      Bone graft