THE COLLEGE OF Dental Medicine
The discipline of learning. The art of caring.

795 E. Second Street, Suite 8
Pomona, CA 91766-2007
Tel: (909) 706-3910 • Fax: (909) 469-8650

The Dental Center at Western University
Oral Surgery Referral Form

Please complete the form and fax it to: (909)469-8650. The first appointment cost for most patients is $157.00. Please ask your patient to contact The Dental Center at (909)706-3910 to schedule an appointment once this form is sent.

Today's Date:_____

Patient Name:_____

Patient Primary Telephone :_____ **Other phone number:**_____

Patient Date of Birth:_____

Please indicate which teeth to be extracted: _____

(Place an "X" over the teeth you wish to extract after you print the form)

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

Other Procedures:
☐ Alveoloplasty ☐ Biopsy ☐ Bone Graft ☐ Dental Implant

Comments:

_____

_____

_____

Name of Referring of Dentist: _____

Address: _____

Phone Number: _____

Signature of Referring Dentist:_____

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