INTEGRITY
ORAL SURGERY

Referral Form

Dr. Atul Deshmukh
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office@integrityoralsurgery.com

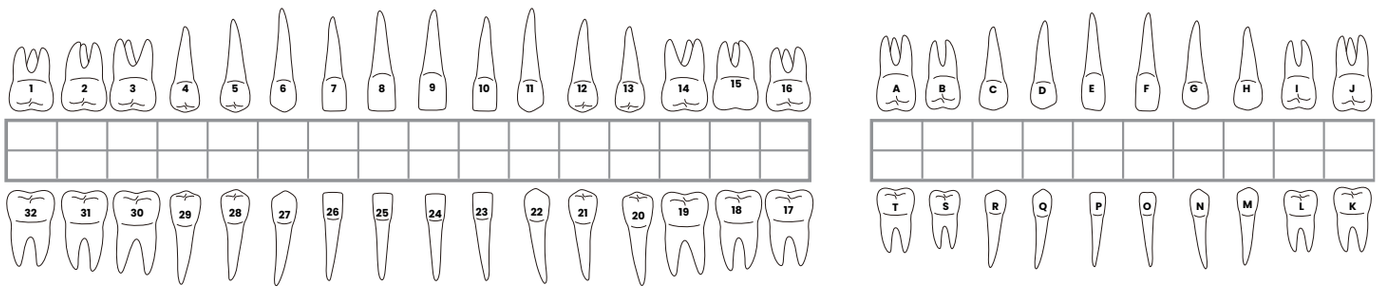
PATIENT NAME: _____ **PATIENT PHONE #:** _____

REFERRED BY: _____ **DATE:** _____

Would you like us to contact your patient?

☐ Yes ☐ No

Please circle teeth to be removed or list work to be done.



** Please note : Third molar and implant consults/treatments require a current pano or CT scan.*

X-RAYS

☐ Attached ☐ Emailed ☐ Mailed ☐ Given to patient ☐ Needed

EVALUATE TREATMENT

☐ Extraction ☐ Expose & Bond ☐ Frenectomy ☐ Implants ☐ Biopsy

☐ Bone Graft ☐ Other: _____

PROPOSED IMPLANT TREATMENT

☐ Fixed ☐ Locators ☐ Temporary Anchorage Device

☐ All-on-4® treatment concept

COMMENTS