



Please check (✓) the doctor & office you are referring to then send to that office's e-mail or fax number.

REQUIRED FIELDS — Please fill out completely

Date _____ Appt. Date _____

Patient's Legal Name _____

Pt. Ph. No. _____ Pt. DOB _____

Referring Dr. _____

Referring Dr. Phone No. _____

Current X-Ray? Yes No Date Taken: _____

Comments _____

Orthognathic

Biopsy of _____ Location: _____

Dental Implant # _____ Preferred System: _____

Other _____

Please extract (mark with X)

Surgical exposure of impacted tooth (please circle)

Oak Ridge

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 Dr Johnson

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