Avon Oral & Maxillofacial Surgery Referral Form

PATIENT INFORMATION:

Today's Date: _____

First Name _____ Last Name _____ Date of Birth _____

Parent / Guardian Name _____

Contact Telephone _____ Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment: ☐ Yes ☐ No

Treatment _____

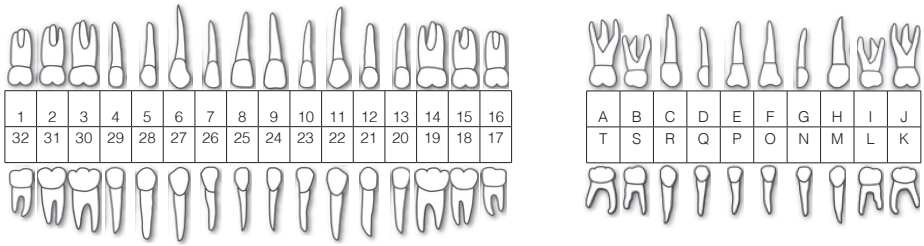
REFERRING DOCTOR'S INFORMATION:

Referred By _____ Telephone _____

E-Mail Address _____

PROCEDURES:

☐ Extraction (see below)
☐ Alveoloplasty
☐ Biopsy
☐ Incision & Drainage
☐ Lesion Evaluation
☐ Exposure
☐ Torus Removal
☐ Infection
☐ Expose & Bond
☐ Frenectomy
☐ Other



Please Verify Teeth For Extraction _____

CONSULTATIONS:

☐ Bone Grafting
☐ Orthognathic Evaluation
☐ Pre-Prosthetic
☐ Implants: ☐ Immediate ☐ Delayed
☐ Ridge Augmentation
☐ Oral / Facial Lesion
☐ Other

Implants: **Surgical Template:**

RADIOGRAPHS OR CLINICAL PHOTOS:

☐ Being Mailed
☐ Given To Patient
☐ Please Take
☐ No X-Ray
☐ Attached with this referral; if X-Rays are attached, what date were they taken _____

CASE NOTES:

AVON ORAL & MAXILLOFACIAL SURGERY

Please call to schedule an appointment at 317-272-2200 or visit avonoms.com.

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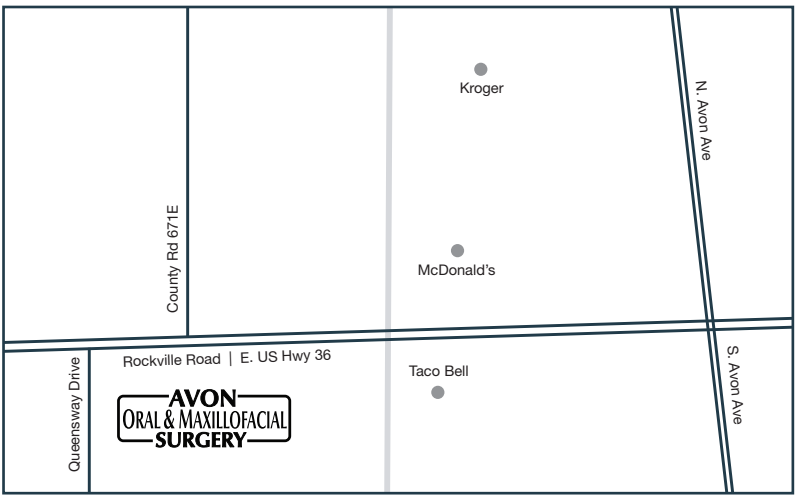
Avon, IN 46123



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