M·SHANE STEVENSON·DMD·MD
ORAL MAXILLOFACIAL SURGERY

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INTRODUCING: _____ REFERRAL IS THE COURTESY OF: _____

TODAY'S DATE: ____/____/____ PATIENT ADDRESS: _____

BIRTHDATE: ____/____/____ GENDER: ☐ MALE ☐ FEMALE CONTACT PHONE: _____

Oral Surgery Procedures To Be Performed

☐ Alveoloplasty ☐ Biopsy/Excision ☐ Expose/Bond

☐ Frenectomy ☐ Incision/Drainage ☐ Trauma

☐ Extraction, Teeth# _____ Would you like for us to discuss implants? ☐ Yes ☐ No

☐ Other: _____

Please Circle Teeth/Area To Be Treated

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

R	A	B	C	D	E	F	G	H	I	J	L
	T	S	R	Q	P	O	N	M	L	K	

Consultation Requested

☐ Dental Implants ☐ Bone Graft ☐ Facial Trauma/Reconstructive Facial Surgery

☐ Orthognathic Evaluation ☐ Pathology Internal/External ☐ Other _____

Radiographs

☐ Enclosed ☐ Given to patient ☐ Please take new ones

Management, Medical or Treatment Concerns: _____

_____

_____

_____
Referring doctor's signature

PLEASE FAX OR MAIL THIS FORM TO OUR OFFICE. THANK YOU!