Oral
Surgery of
Springfield

SPECIALIST IN ORAL & MAXILLOFACIAL SURGERY
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Diplomate of the American Board of Oral and Maxillofacial Surgery

This is to introduce _____
Patient's Name

Today's date _____ Date of birth: _____

☐ Evaluate, treat and report back findings and recommendations

☐ Orthognathic surgery consultation

☐ Dental implant consultation

☐ Extract teeth #'s (circle below):

				A	B	C	D	E	F	G	H	I	J			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
RIGHT																LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			

_____

_____

_____

_____

☐ Radiographs enclosed (Copies Only Please) ☐ E-mailed

☐ The patient will contact your office for an appointment

☐ Contact the patient as soon as possible: Phone # _____

☐ Contact me before treatment is rendered: Phone # _____

Sincerely,

_____ _____ _____
Referring Doctor Signature | Print Name | Date

We at Oral Surgery of Springfield appreciate the opportunity to assist in the care of your patient. Please remind your patient that payment is expected at the time of service and that they should bring their insurance card/information to every appointment. Please feel free to call our office for any questions or concerns. **Thank you.**