CHERRY LOG ORAL SURGERY

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Date _____

PATIENT INFORMATION:

First Name _____ Last Name _____ Date of Birth _____

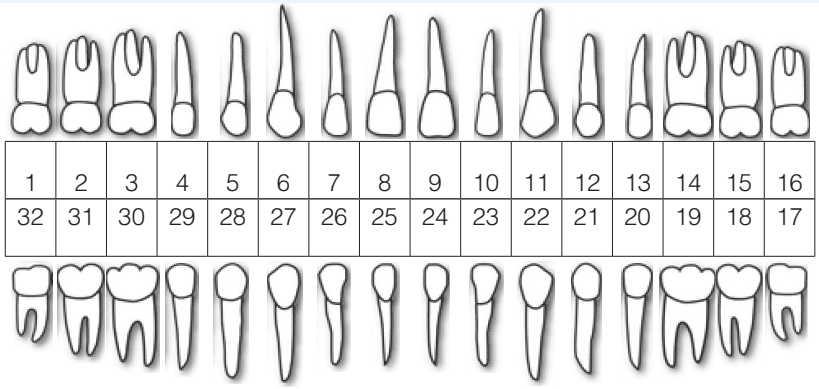
Contact Telephone _____

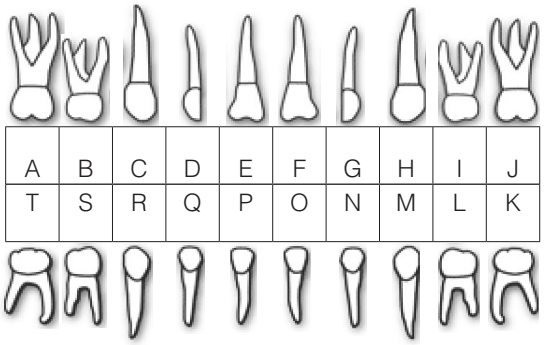
REFERRING DOCTOR'S INFORMATION:

Referred By _____

PROCEDURES:

- ❑ Extraction (see below)
- ❑ Pre-Prosthetic
- ❑ Biopsy
- ❑ Infection
- ❑ Expose & Bond
- ❑ Frenectomy
- ❑ Apicoectomy
- ❑ Trauma
- ❑ Implant
- ❑ Other





Please Verify Teeth For Extraction _____

RADIOGRAPHS OR CLINICAL PHOTOS:

- ❑ Given To Patient
- ❑ No X–Ray

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM
AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL

- ❑ Attached With This Referral; if X-Rays are attached, what date were they taken _____

CASE NOTES: