

**FAX REFERRAL**

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Online registration: [www.oralsurgerysatx.com](http://www.oralsurgerysatx.com)



Referring: \_\_\_\_\_ Date \_\_\_\_\_  
Doctor's Signature

Patient \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_ - -

Address \_\_\_\_\_ Home # \_\_\_\_\_ Alternate # \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_ - -

Dental Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

(Note: Medical Insurance is necessary for Trauma, Pathology & some Third Molar cases)

**Reason For Referral**

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	

Extractions # \_\_\_\_\_  
(Please write in AND circle on the chart)

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

Implants (Teeth/Area) \_\_\_\_\_

Pathology (Indicate on drawing) \_\_\_\_\_  
3D Cone Beam CT Scan (reason) \_\_\_\_\_  
Other Please Explain \_\_\_\_\_

**I Am Sending:**

Panorex \_\_\_ PAX \_\_\_ Date taken: \_\_\_\_\_

Have your office take necessary radiographs

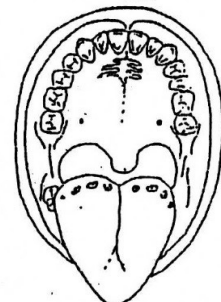
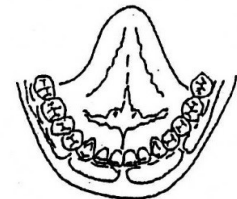
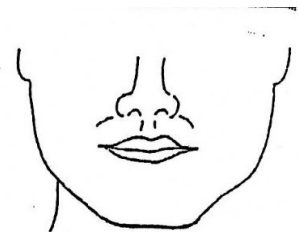
Emailed X-ray to: [aos2@oralsurgerysatx.com](mailto:aos2@oralsurgerysatx.com)

**Appointment Status:**

An appointment was made by our office:  
Date : \_\_\_\_\_ Time: \_\_\_\_\_

**Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**\*\*A REFERRAL MUST BE RECEIVED PRIOR TO A CONSULTATION OR SURGERY\*\* ..**