Patient's Name:_____ Date of Birth:_____

Phone Number:_____ Date of Referral:_____

Reason for Referral

- ❍ Third Molar Evaluation
- ❍ CT Scan and Surgical Planning
- ❍ Bone Grafting
- ❍ Implant(s) Preference (Nobel/ BioHorizons/ Biomet-3i)
  - Single-
  - Multiple-
  - Implant Bridge-
  - Implant Retained Denture-
  - Hybrid Reconstruction- Maxilla/Mandible (All-on-Four/TeethXpress/RevitaliZe)
- ❍ Removal of Tori UR UL LR LL
- ❍ Lesion Evaluation
- ❍ Frenectomy
- ❍ Exposure and Bonding
- ❍ Temporary Anchorage Device
- ❍ Alveoplasty
- ❍ Cosmetic Surgery (Botox/Fillers/Implants/Reduction Cheiloplasty/Ear lobe repair)
- ❍ TMJ/Myofascial Pain
- ❍ Gingivectomy
- ❍ Infection
- ❍ Apicoectomy
- ❍ Dental Anxiety/Sedation extractions

Teeth to be Extracted:

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

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

Supernumerary(s):

Referring Dentist:_____ Phone Number:_____

Office Address:_____

Special Notes:_____

rockwelloralandfacialsurgery@gmail.com

ROCKWELL ORAL AND FACIAL SURGERY

675 North Highland Avenue NE #100, Atlanta, GA 30306 **ph:** 678 732 9413

Monday–Friday 7:30–4:00 **Saturday** 8:00–12:00 **fax:** 404 500 5483