TARRANT COUNTY
ORAL & MAXILLOFACIAL SURGERY

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Referral for Surgical Consultation

Date:_____
Introducing:_____
Date of Birth:_____
Patient Phone #:_____
Referring Physician Name:_____
Practice Name:_____
Referring Office Phone #:_____
Notes:_____
_____
_____
_____

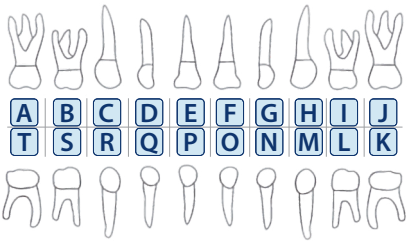
Reason for Consultation:

- ☐ Implants
- ☐ Wisdom Teeth
- ☐ Extraction/s
- ☐ Expose & Bond
- ☐ Oral Pathology
- ☐ Facial Trauma
- ☐ TMJ Eval
- ☐ Other

Dental Insurance Carrier:_____ Phone:_____
Subscriber Name:_____ DOB:_____
Subscriber ID #:_____ Group#:_____

Patients:

Please bring this referral form, any radiographs and a list of all current medications with dosages to your appointment.



Doctors:

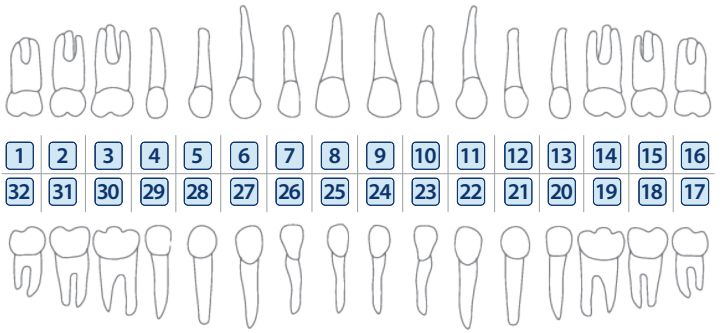
Please confirm the teeth for extraction:_____
_____

_____
Referring Doctor Signature

XRAY:

- ☐ Emailed
- ☐ Mailed
- ☐ Sent with Patient

Date Taken:_____



*Parents must accompany minors

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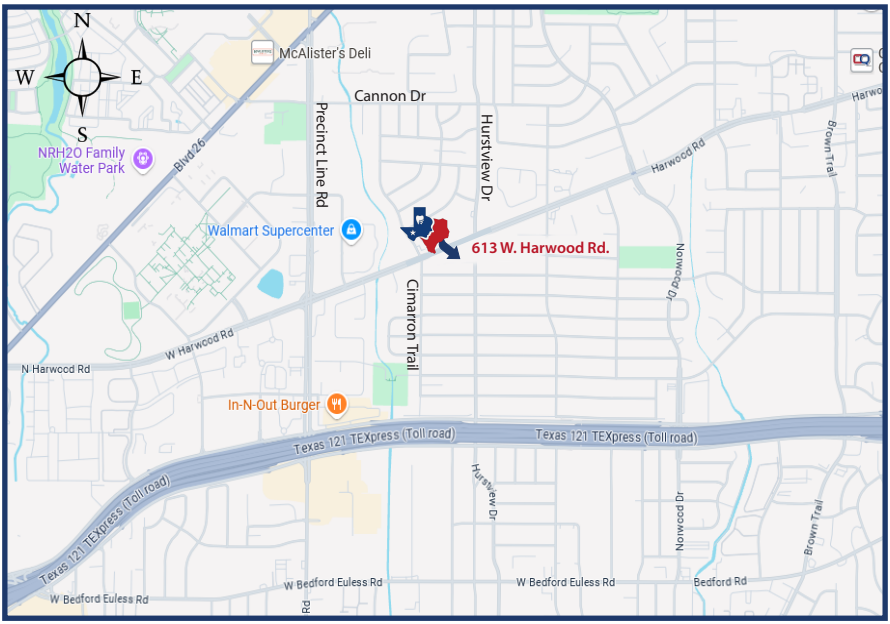

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