GARLAND
ORAL SURGERY
& DENTAL IMPLANT CENTER

Referral Request

Patient Name _____

History_____

_____

_____

_____

SERVICES REQUESTED:

___Consultation	___Impaction	___Pre-Prosthetic Surg.
___Infection	___Implant	___Surgical exposure
___Panorex X-Ray	___Orthognathic Surg..	___IV Sedation
___Alveoloplasty	___X-rays mailed	___Gen. Anesthesia
___Biopsy	___X-rays given	
___Extraction	to patient	

___Other_____

_____

_____

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

Right Left

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

Additional Comments:

Signed _____ Date_____
Referring Doctor

Referring Dr.'s Name_____

APPOINTMENT REQUEST

Date:_____ Time:_____

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Garland, Texas 75041
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