Signature
ORAL SURGERY & IMPLANTS

## Patient Information

Referring Doctor: _____ Date: _____

Patient Name: _____ DOB: _____

Phone Number: _____

## Reason for Referral

- ☐ Extractions _____
- ☐ Implants _____
- ☐ Grafting _____
- ☐ Surgical Exposure #_____
- ☐ Wisdom Teeth
- ☐ Brand _____
- ☐ Pathology
- ☐ Orthognathic

## Radiographs Being Sent

☐ Pano ☐ CBCT ☐ BWX ☐ PA ☐ FMX

Date Taken:_____

☐ Please take necessary radiographs

## Appointment Status

☐ Has an appointment: Date: _____ Time: _____

☐ Please call patient

☐ Patient will call for an appointment

## Notes:

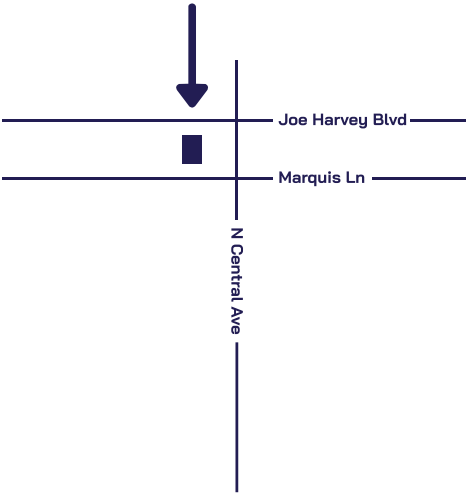
# Signature
ORAL SURGERY & IMPLANTS

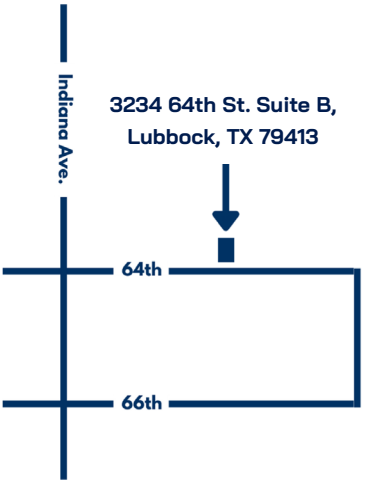
Justin Bonner, DDS

Cabel McDonald, DDS

Lance Read, DDS

**1215 Joe Harvey Blvd**
**Hobbs, NM 88240**

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