Marshall A Baldassarre, DMD
PRACTICE LIMITED TO ORAL & MAXILLOFACIAL SURGERY
DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

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ORAL AND MAXILLOFACIAL SURGERY PATIENT REFERRAL

Date:
Referring Dentist:

Patient Name:

Home phone: Work Phone: Cell Phone:

Patient Email address:

Primary Concern/ Reason for Referral:

- ☐ EMERGENCY EVALUATION
- ☐ EVALUATE/ BIOPSY ORAL LESION; LOCATION:
- ☐ EXTRACTIONS:
- ☐ LOCAL:
- ☐ IV SEDATION/GENERAL ANESTHESIA:
- ☐ PERIAPICAL SURGERY:
- ☐ DENTAL IMPLANT:
- ☐ HYBRID/ ALL ON 4: DENTAL IMPLANT PLACEMENT
- ☐ RIDGE AUGMENTATION/RECONSTRUCTION:
- ☐ OTHER/NOTES:

Please Specify Diagnostic Information being forwarded:
Periapicals Date:
Panoramic Image Date:
3D CBCT Date:

Thank you for allowing us to be a part of your dental team. We take your trust in us very seriously. Please let me know how we can help your patient achieve the oral health they desire.

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NASHUA LOCATION 505 WEST HOLLIS ST. SUITE 206 • NASHUA, NH 03062 PERIODONTIST 603.881.5580 ORAL & MAXILLOFACIAL SURGEON 603.881.5921