BEDFORD
ORAL SURGERY

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:	☐ LOCAL:
☐ EXTRACTIONS:	☐ IV SEDATION/GENERAL ANESTHESIA:
☐ DENTAL IMPLANT(S):	
☐ HYBRID/ ALL ON 4: DENTAL IMPLANT PLACEMENT/ IMPLANT SUPPORTED DENTURE	
☐ RIDGE AUGMENTATION/RECONSTRUCTION:	
☐ PERIAPICAL SURGERY:	
☐ 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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