611 E. Bloomingdale Ave. STE C
Brandon, FL 33611
Phone: 813-820-0071
Fax: 813-820-0072
Email: info@mydentalday.com
Web: www.mydentalday.com

Oral Surgery Referral

Patient Name ____ Age______________

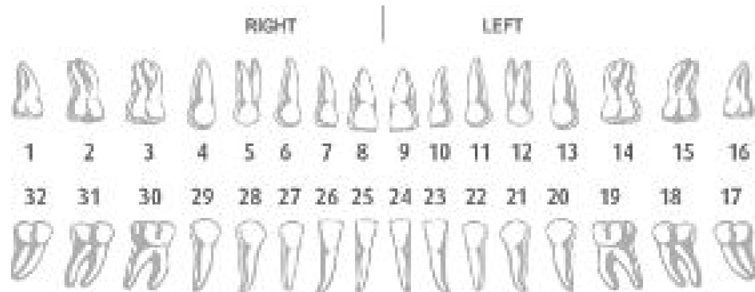
Phone: ____________________ Parent's Name:____________________________________

Special Health Concerns: ____

Patient Insurance Information: ____

Reason for referral:

☐ Surgical Removal of Erupted Tooth
☐ Soft Tissue Impaction Tooth #____
☐ Partial Bony Impaction Tooth # ____
☐ Full Bony Impaction Tooth #____
☐ Surgical Removal of Root Tip ____
☐ Bone Graft
☐ Implants
☐ Removal of Tori
☐ Biopsy
☐ Alveoplasty
☐ Frenectomy
☐ Consultation for Cosmetic Surgery



Notes:____

____

Does Patient require premedication? ☐ Yes ☐ No

Antibiotic used: ____

Any Medical Concerns requiring attention: ____

Referring Doctor information:

☐ X-rays Given to Patient ☐ X-rays mailed/E-mailed ☐ Needs X-rays

Referring Doctor: ________________________________ Phone: _______________________

Email address: _______________________ Date: ___________________________________