



Referring Doctor: _____ Date: _____

Patient Name: _____ Phone #: _____

Reason for Referral:

- Localized Exam/Pain (Area: _____)
- Full Mouth Exam/Hygiene Visit
- Pediatric Exam
- Evaluation for Obstructive Sleep Apnea Appliance
- Other: _____
- Dry Mouth /Oral Condition
- Wisdom Teeth Evaluation
- Cosmetic Consultation
- Oral Cancer Screening

Comments: _____

- Please call before examination
- X-Rays will be mailed/e-mailed

Your confidence is greatly appreciated.

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