PROGRESSIVE
IMPLANTOLOGY & PERIODONTICS

Oral Surgery Referral Form

Dr. Andrew T. Bracci, D.M.D.

Referred by: ______________________________ Date: ____________

Patient Name: ____

Home: (   ) __________________ Work: (   ) ___________________

Date of Appointment: __________________ Time: _______ AM/PM

X-rays Enclosed: ____

PERMANENT

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LT

PRIMARY

	A	B	C	D	E	F	G	H	I	J	
RT	T	S	R	Q	P	O	N	M	L	K	LT

SERVICES REQUESTED (Please check all that apply)

- ☐ Extraction (s)
- ☐ Preprosthetic
- ☐ Exposure, Bond & Ligate
- ☐ Biopsy
- ☐ Implant
- ☐ Other
- ☐ Third Molar Consult
- ☐ Frenectomy

Remarks/Pertinent History: ______________________________________

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Authorized by: ____________________________ Date: ____________
Referring Dentist

• All children under 18 years of age must be accompanied by a legal guardian for consultation and treatment.
• Consultation is required for all patients with cardiac problems and/taking blood thinners, fosomax or need conscious sedation.
• In the event you must cancel your appointment, please notify the office at least 72 hours in advance.

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