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Oral Surgery Referral

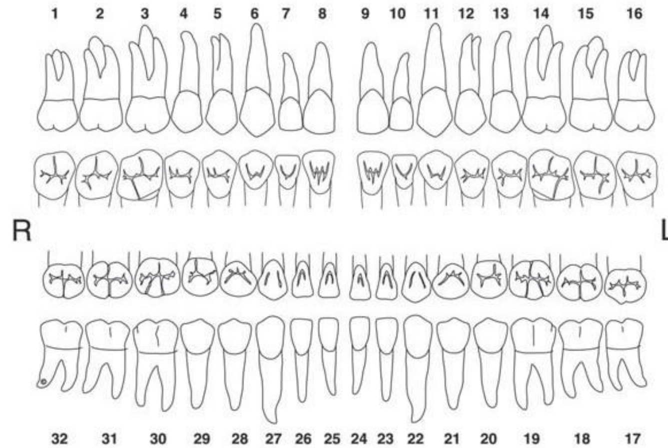
Patient Name ____ Age_____________

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: Kevin S. Welinsky DDS Phone: 410-321-8480

Email address: wdctowson@gmail.com Date: ______________________