Maui Oral & Maxillofacial Surgery

www.MauiOralSurgery.com

Todd G. Carter, D.M.D.

Diplomate of the American Board of Oral & Maxillofacial Surgery

Tel: 808.244.7634

PATIENT INFORMATION:

Today's Date _____

First Name _____ Last Name _____ Date of Birth _____

Parent / Guardian Name _____

Contact Telephone _____ Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No • ❑ Patient will call for appointment ❑ Please call patient

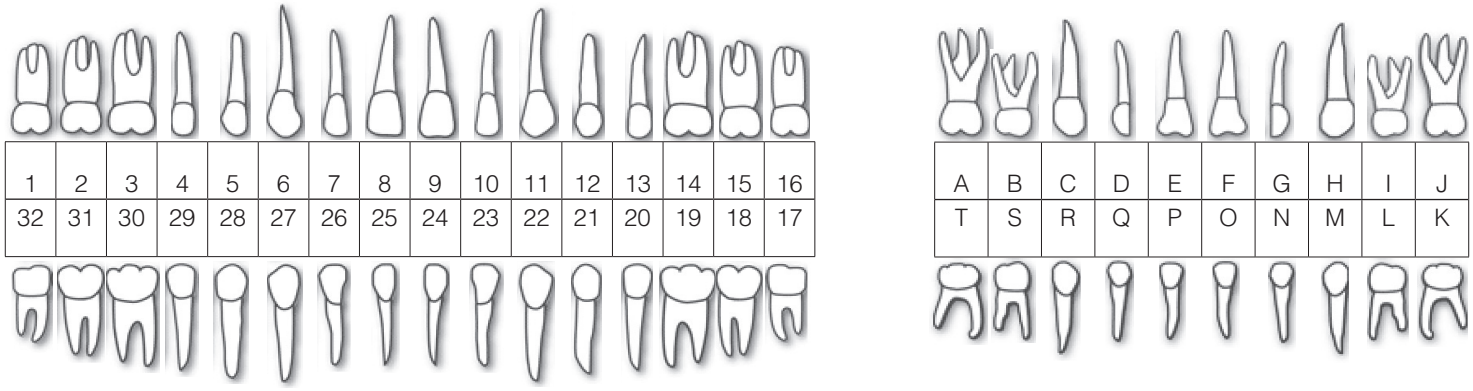
REFERRING DOCTOR'S INFORMATION:

Referred By _____ Telephone _____

E-Mail Address _____

REASON FOR REFERRAL:

❑ Extraction (see below)



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

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

Please Verify Teeth For Extraction _____

Socket Preservation Grafting? ❑ Yes ❑ No

❑ Implant
❑ Biopsy (area and describe): _____
❑ Orthodontic anchorage / TAD
❑ Expose and bond
❑ Infection
❑ Frenectomy
❑ Torus removal
❑ Tuberosity reduction
❑ Vestibuloplasty
❑ Apicoectomy
❑ Trauma / fracture
❑ Cyst / neoplasm
❑ Orthognathic evaluation
❑ TMJ

❑ Other _____

RADIOGRAPHS OR CLINICAL PHOTOS:

❑ Being Mailed
❑ Given To Patient
❑ Please Take
❑ No X–Ray

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.

AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

❑ Attached With This Referral; if X-Rays are attached, what date were they taken _____

CASE NOTES: