California Oral Surgery Center - Stockton Oral Surgery

FAX REFERRAL FORM – FAX# (209) 473-0967

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Date________________

Referring Doctor ______________________________ Office # ____________________________ Fax # ____________________________

Name of Patient ____

Patient Address ____

____

DOB ____ SSN ____

Home Phone_______________________ Daytime Phone __________________________ Cellular Phone __________________________

Minors MUST be accompanied by an adult.

Primary Insurance Coverage

Insured's Name ____

DOB ____

SSN ____

Dental Insurance Co. ____

Insurance Co. Phone # ____

Secondary Insurance Coverage

Insured's Name ____

DOB ____

SSN ____

Dental Insurance Co. ____

Insurance Co. Phone # ____

PLEASE SEND X-RAYS PRIOR TO CONSULTATION

PLEASE SEND A PANOREX X-RAY WHEN REFERRING PATIENT FOR WISDOM TEETH.
PLEASE SEND APPROPRIATE X-RAY FOR ALL OTHER REFERRALS. DO NOT SEND BITE WING X-RAYS.

Reason for Referral ____

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Indicate Teeth for Removal

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

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