trillium
ORAL SURGERY AND IMPLANTOLOGY

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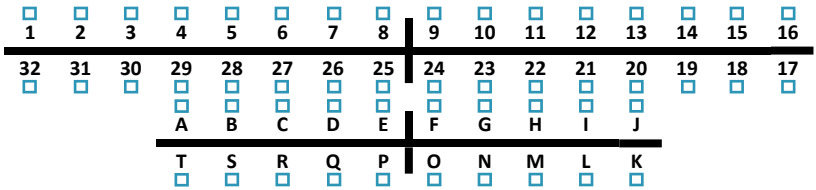
Patient Name: _____

Please mark tooth/teeth below:



☐ Extraction(s) ☐ Implant(s) ☐ Pre-Prosthetic ☐ Orthognathic
☐ Pathology ☐ TMJ ☐ Bone Grafting ☐ Soft Tissue Grafting
☐ Other_____

Future Treatment Planned: _____

_____

Radiographs: ☐ Required ☐ Attached ☐ Emailed (frontdesk@trilliumoralsurgery.com)
☐ Sent via website Date of Radiographs: _____

INSTRUCTIONS TO PATIENTS:

- BRING THIS REFERRAL FORM (and any x-rays you were given) TO YOUR APPOINTMENT.
- Please complete patient registration forms at **www.trilliumoralsurgery.com** prior to your appointment.
- GENERAL ANESTHESIA (SLEEP) INSTRUCTIONS: No food or liquid should be taken for six hours before your scheduled appointment. A responsible adult is required to accompany patient and drive patient home.
- Minors must be accompanied by a parent or legal guardian.

Referred by: Dr. _____ **Date:** _____