OM3 ORAL MAXILLOFACIAL & IMPLANT SURGERY

❑ Peter H. Kim, DDS
❑ Serv S. Wahan, DMD, MD
❑ Daniel T. Brady, DDS
❑ Dustin Altmann, DMD
❑ Michael Gross, DMD, MD

16708 Bothell Everett Hwy, 100
Mill Creek, WA 98012
Mill Creek
425-743-0227

3229 Hoyt Ave, Ste A
Everett, WA 98201
Everett
425-258-2646

16410 Smokey Point Blvd, Ste 103
Arlington, WA 98223
Arlington
360-658-8822

2606 Bickford Ave, Ste 3
Snohomish, WA 98290
Snohomish
360-799-6812

PATIENT INFORMATION:

Today's Date_____

First Name_____ Last Name_____ Date of Birth_____

Parent / Guardian Name_____

Patient Phone Number_____ Contact E-Mail Address_____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No

Insurance Company Name_____ Insurance ID #_____

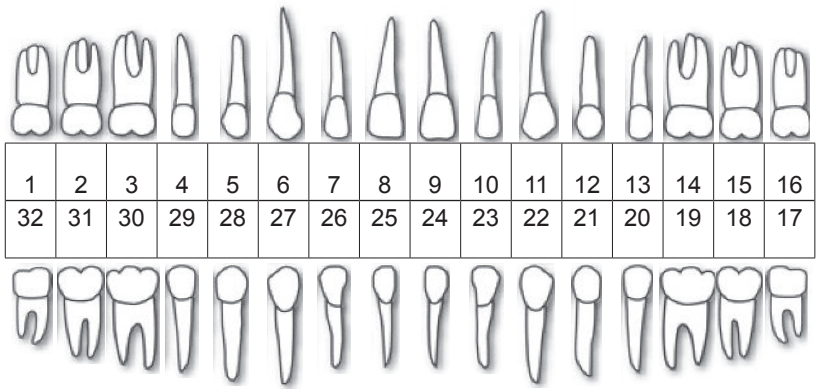
REFERRING DOCTOR'S INFORMATION:

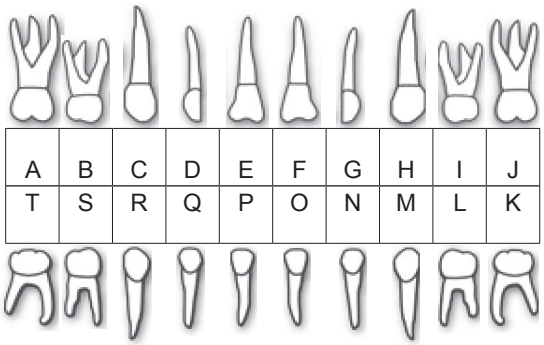
Referred By_____ Office Tel._____

E-Mail Address_____

CONSULTATIONS:

❑ Extraction (see below)
❑ Alveoplasty
❑ Biopsy
❑ Incision & Drainage
❑ Lesion Evaluation
❑ Exposure
❑ Hard Tissue
❑ Infection
❑ Expose & Bond
❑ Soft Tissue
❑ Frenectomy
❑ Apicoectomy
❑ TMJ
❑ Implants: ❑ Immediate ❑ Delayed
❑ Orthognathic Evaluation
❑ Pre–Prosthetic
❑ Cleft Lip & Palate
❑ Cosmetic
❑ Ridge Augmentation
❑ Oral / Facial Lesion
❑ Bone Grafting
❑ Other





Please Verify Teeth For Extraction_____

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 _____

TREATMENT: