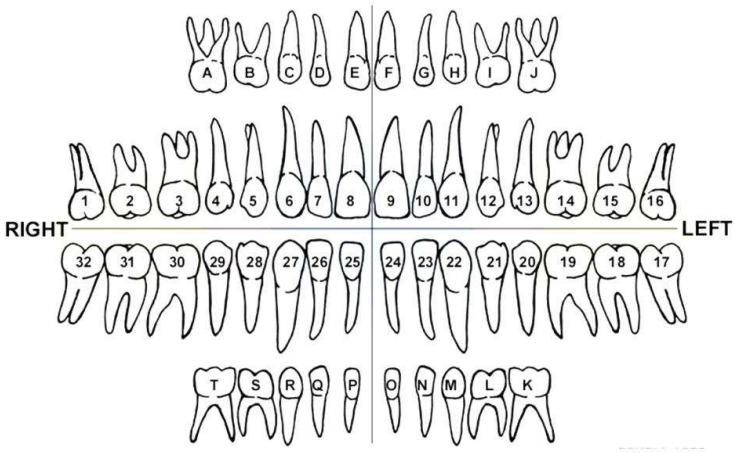
Kerrville
Oral & Maxillofacial Surgery
Implants, Extractions, Facial Reconstruction

REFERRAL FORM

Patient: _____ Phone : _____ Date: _____

From Dr. _____ Dental Office Phone: _____

Please mark teeth or area to be treated:



Procedures:

- ☐ Consultation
- ☐ Extractions
- ☐ Dental Implants
- ☐ Bone Grafting
- ☐ Oral Pathology/Biopsy
- ☐ TMJ Disorders
- ☐ Surgical Expose & Bond
- ☐ Soft Tissue Augmentation
- ☐ Tori Removal/Alveoloplasty
- ☐ Other:_____

Radiographs:

- ☐ Radiograph(s) emailed
- ☐ Radiograph(s) sent with patient
- ☐ Patient will need radiographs

Comments:

_____

_____

_____

_____

Our office is committed to providing you with the highest quality of care possible. To help us in scheduling your appointment, please remember the following:

- Patients under 18 years of age must be accompanied by a parent or legal guardian.
- Please bring this referral slip, radiographs, medical history and medication list to your initial consultation appointment.

JAMES D. LUSSIER, DDS • 204 WESLEY DRIVE • KERRVILLE, TEXAS 78028
INFO@KERRVILLEOMS.COM • (830) 895-3494 • FAX (830) 896-3390 • WWW.KERRVILLEOMS.COM