WEST COAST
ORAL & MAXILLOFACIAL SURGERY

DRS. ALI M.M. SADEGHI T. BARR J. EPSTEIN

Certified Specialists in Oral & Maxillofacial Surgery & Oral Medicine

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WE ARE REFERRING

Patient_____ Birth Date_____

Guardian (if applicable)_____

Address_____ City_____ PC_____

Telephone Res._____ Cell_____

Referred by_____ Phone_____

DENTAL INSURANCE INFO: **Date Referred**_____

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Radiograph

☐ Take ☐ Enclosed ☐ Emailed ☐ Mailed ☐ Given to Patient

Date Radiograph Taken_____

Appointment Date_____ Time_____ Dr._____

Appointment Information: This time is reserved specifically for you. If by necessity, you must cancel your appointment for surgery, please notify us at least **three business days** in advance.

WE ARE REFERRING

- ☐ 3rd Molars
- ☐ Extractions
- ☐ Implants
- ☐ Augmentation
- ☐ Sinus lift
- ☐ Socket graft
- ☐ Ridge
- ☐ Botox
- ☐ Facial Rejuvenation – Cosmetic Filler
- ☐ Recurrent facial pain
- ☐ Saliva gland dysfunction
- ☐ Other _____
- ☐ Alveoplasty
- ☐ Apicoectomy
- ☐ Expose & Bond
- ☐ Frenectomy
- ☐ Infection
- ☐ Lesion
- ☐ TMJ
- ☐ Orthognathic
- ☐ Jaw Fracture/trauma
- ☐ Taste disorder
- ☐ TMD and chronic oral facial pain

Please indicate teeth to be removed or surgery to be performed

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	
R																	**L**
	55	54	53	52	51				61	62	63	64	65				
	85	84	83	82	81				71	72	73	74	75				

Comments_____

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We request payment for office services at the time they are provided. For your convenience, we accept visa, mastercard, & direct debit. We will be pleased to submit you applicable claim form upon completion of your treatment so that you can be reimbursed for your portion directly by your dental insurance carrier.

Please forward by fax or email to our office and give this original to the patient.