SOUTH SHORE ORAL SURGERY ASSOCIATES

DR. STEVEN J. VERVENIOTIS | DR. RICHARD M. MIRRA

PATIENT REFERRAL

First Name		Last Name	
Birth Date		Phone #	

Treatment Requested:

- ❑ Wisdom Teeth Removal
- ❑ Evaluation for Implants
- ❑ Botox
- ❑ Pre-prosthetic Surgery
- ❑ Periapical Surgery
- ❑ Extraction(s)
- ❑ Biopsy
- ❑ Facial Fillers
- ❑ Evaluate Lesion/Growth
- ❑ Orthodontic Exposure
- ❑ Bone Graft
- ❑ Trauma
- ❑ TMJ/Facial Pain Evaluation
- ❑ Incision & Drainage
- ❑ Facial Reconstructive Surgery
- ❑ Other ____

CBCT Scan Required? ❑ Yes ❑ No

Please Indicate Tooth to be Treated

❑ 01	❑ 02	❑ 03	❑ 04	❑ 05	❑ 06	❑ 07	❑ 08	❑ 09	❑ 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 ❑

Remarks:

Referring Provider Signature		Date	
Printed Name		Phone	
APPOINTMENT INFORMATION			
Date		Time	

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