

Introducing _____ Today's Date ____/____/____

Patient's Phone No. _____ Patient's D.O.B. _____

Referral Made by _____ @ _____
Staff Member Doctor or Practice Name

- Appointment has been made: Date: _____ Patient will call
Time: _____ Please call Patient

EVALUATION

- Infection Oral/Facial Trauma Orthognathic TMJ/ Facial Pain Other

PROCEDURES REQUESTED

- | | | |
|---|--|---|
| <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Extraction(s) | <input type="checkbox"/> Implant(s) |
| <input type="checkbox"/> Lesion | <input type="checkbox"/> Tissue Graft | <input type="checkbox"/> Extraction & Implant |
| <input type="checkbox"/> Exposure/ Bond | <input type="checkbox"/> Bone Graft | <input type="checkbox"/> Fixed Hybrid Prosthesis |
| <input type="checkbox"/> Frenectomy | <input type="checkbox"/> Other | Secure Bite® / All-on Four® / Pro-Arch |
| | | <input type="checkbox"/> Implants for OverDenture |

IMPLANTS

Preferred System Straumann Tissue Level Bone Level Astra EV	Planned Restoration Screw Retained Cement Retained	Abutment DDS TXOSS <input type="checkbox"/> TXOSS to provide CAD/ CAM Model & Analog
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	A	B	C	D	E	F	G	H	I	J							
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	T	S	R	Q	P	O	N	M	L	K							

Radiographs: E-mail to DDSinfo@txoss.com Mailed Given to patient none
Other _____

Please Send Cards Please Send Referral Slips _____ Doctor's Signature

• You may also refer your patient online at www.TXOSS.com •

Please Scan/Email to DDSInfo@txoss.com or Fax to 817-552-3224 before sending this form with your patient.

PATIENT INSTRUCTIONS: PLEASE REGISTER ONLINE AT WWW.TXOSS.COM