Texas Oral Surgery Specialists

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Diplomate American Board of Oral & Maxillofacial Surgery

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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

- ❑ Wisdom Teeth
- ❑ Lesion
- ❑ Exposure/ Bond
- ❑ Frenectomy
- ❑ Extraction(s)
- ❑ Tissue Graft
- ❑ Bone Graft
- ❑ Other
- ❑ Implant(s)
- ❑ Extraction & Implant
- ❑ Fixed Hybrid Prosthesis
  Secure Bite® / All-on Four® / Pro-Arch
- ❑ Implants for OverDenture

Implants

Preferred System
Straumann
Tissue Level Bone Level
Astra EV

Planned Restoration
Screw Retained
Cement Retained

Abutment
DDS TXOSS
❑ TXOSS to provide CAD/ CAM Model & Analog

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