Smileworks

ORAL SURGERY / IMPLANTS REFERRAL FORM

Practitioner Name	Patient Name
Practice Name & Address	Patient Contact Number
	Patient DOB
Practitice Contact Number	Male ☐ Female ☐
Practitice Contact Email	Patient Contact Email

PROCEDURE

- Implants ☐
- Minor oral surgery ☐
- Sinus augmentation ☐

TOOTH / TEETH REQUIRING TREATMENT

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
R															L
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

TREATMENT REQUIRED / HISTORY

RELEVANT MEDICAL HISTORY

SIGNATURE: _____

Is the patient possibly pregnant? YES ☐ ☐ NO

RADIOGRAPHS ENCLOSED

- ☐ **OPG**
- ☐ **Periapical**
- ☐ **Other (please specify)**

Please complete and send as a jpeg or PDF to concierge@sexydentistry.com