Oral Surgery Durango

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Durango, CO 81301
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Date: _____

Patient Name: _____

Phone Number: _____

- ☐ X-Rays Enclosed
- ☐ X-Ray Required
- ☐ X-Ray Sent Via Email

Please send to: frontdesk@oralsurgerydurango.com
It is preferred that images are emailed in .jpg format only

Reason For Referral:

_____

_____

_____

_____

For Implant Referral, Please Check Box If Preference:

- ☐ Nobel
- ☐ Straumann
- ☐ Astra

Referring Doctor: _____
Signature