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AARON U. ADAMSON, DMD

Board-Certified Oral & Maxillofacial Surgeon

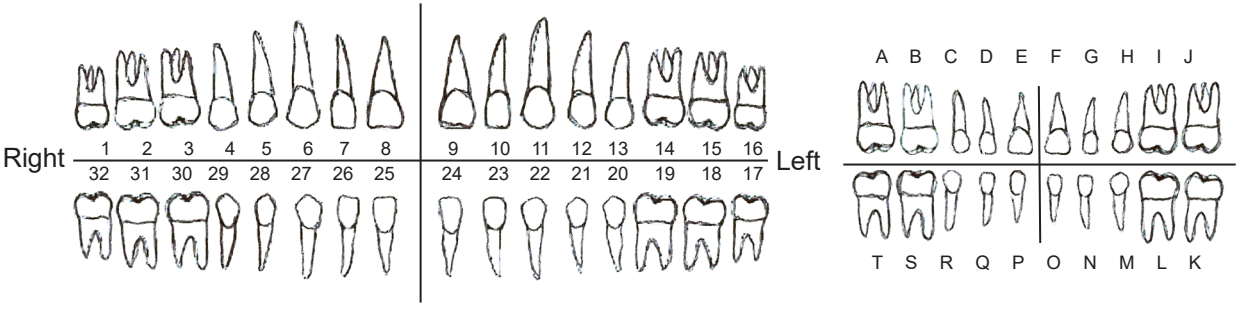
Referring Dr _____ Date _____

Patient's Name _____

DOB _____ Tel # _____

The patient is being referred for evaluation of:

□ Extraction tooth # _____
□ Wisdom teeth # _____
□ Bone grafting # _____
□ Implant # _____
□ Pathology # _____
□ Expose & bond # _____
□ TMJ _____
□ Trauma _____
□ Orthognathic surgery _____
□ Other _____



X-Rays:

□ Sent radiograph to your office □ Patient bringing radiograph □ Please take necessary radiographs

□ Pano □ CBCT

Comments: _____

_____

PATIENT REMINDER

On the day of your appointment, please bring your insurance information, x-rays (if you have them), and a list of your current medications.