

ED ELLIOT, DMD

Board Certified Oral & Maxillofacial Surgeon

315.692.6546

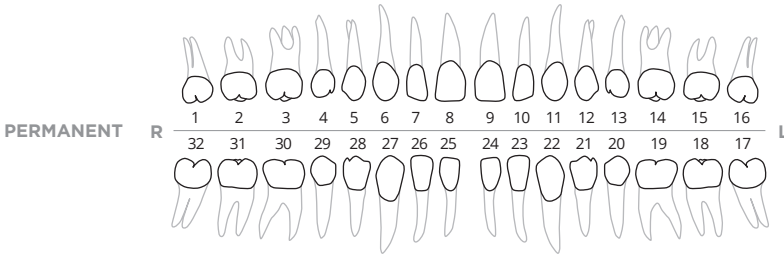
FM.Oral.Surgery



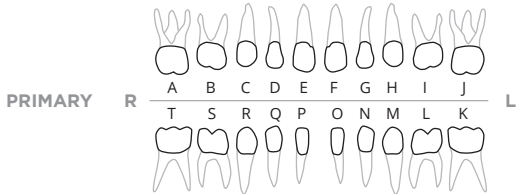
PATIENT NAME _____

PATIENT PHONE (_____) _____ - _____

REFERRED BY DR. _____



TOOTH _____



REASON FOR REFERRAL

- Extraction(s)
- Infection Treatment
- Biopsy of Lesion
- Sinus Augmentation
- Exposure, Bond and Bracket/Chain
- Other _____
- Third Molar Extraction(s)
- Implant Placement(s)
- Alveoloplasty
- Frenectomy
- Botox
- Bone Graft
- Trauma
- Expose Without Bonding
- Extraction and Socket Graft

X-RAYS

- Date taken _____ / _____ / _____
- Emailed
 - Given to the patient
 - Attached with this referral
 - Not taken

We participate with many insurance plans. Please call for more information.