PAUL A. BRANNEN, DMD | Oregon Wisdom Teeth
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PATIENT REFERRAL FORM

Name of Dentist _____ Office Phone Number _____

Name of Patient _____ Patient Phone Number _____

Reason for referral: Wisdom Teeth Orthodontic Extraction Extraction Tissue or Bone Graph Other (see comment)

Teeth to be Treated, Examined, or Extracted

			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
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			

Treatment rendered or additional comments: _____

X-Rays (circle one): Mailed Unavailable Available on Request Sent with Patient

Referring Dr. Signature: _____ Date _____