LARGO DentalOne

ORAL SURGERY REFERRAL FORM

Patient Name: ______________________ Phone No: ______________________

Referring Doctor Name: ______________________ Phone No: ______________________

Address: ______________________

Reason for Referral

- ☐ Extraction(s)
- ☐ Implant(s)
- ☐ Impacted Teeth
- ☐ Pathology
- ☐ Full Arch
- ☐ Augmentation ____ Bone ____ Soft Tissue

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15	☐ 16
			☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	☐ G	☐ H	☐ I	☐ J			
			☐ T	☐ S	☐ R	☐ Q	☐ P	☐ O	☐ N	☐ M	☐ L	☐ K			
☐ 32	☐ 31	☐ 30	☐ 29	☐ 28	☐ 27	☐ 26	☐ 25	☐ 24	☐ 23	☐ 22	☐ 21	☐ 20	☐ 19	☐ 18	☐ 17

Has the patient had previous periodontal therapy?

- ☐ None
- ☐ Prophylaxis Only
- ☐ Antimicrobial Therapy
- ☐ Scaling and Root Planning
- ☐ Crown Lengthening Surgery

Have you advised the patient of the possibility of extraction of any teeth? Yes ☐ No ☐

If yes which teeth? ______________________

Does the patient require premedication? Yes ☐ No ☐

Antibiotic used: ______________________

Radiographs:

- ☐ Please take/send copy
- ☐ Patient will bring copy
- ☐ I will send/Please return
- ☐ Emailed info@largodentalone.com

Your Restorative Plans

____

Comments: ______________________

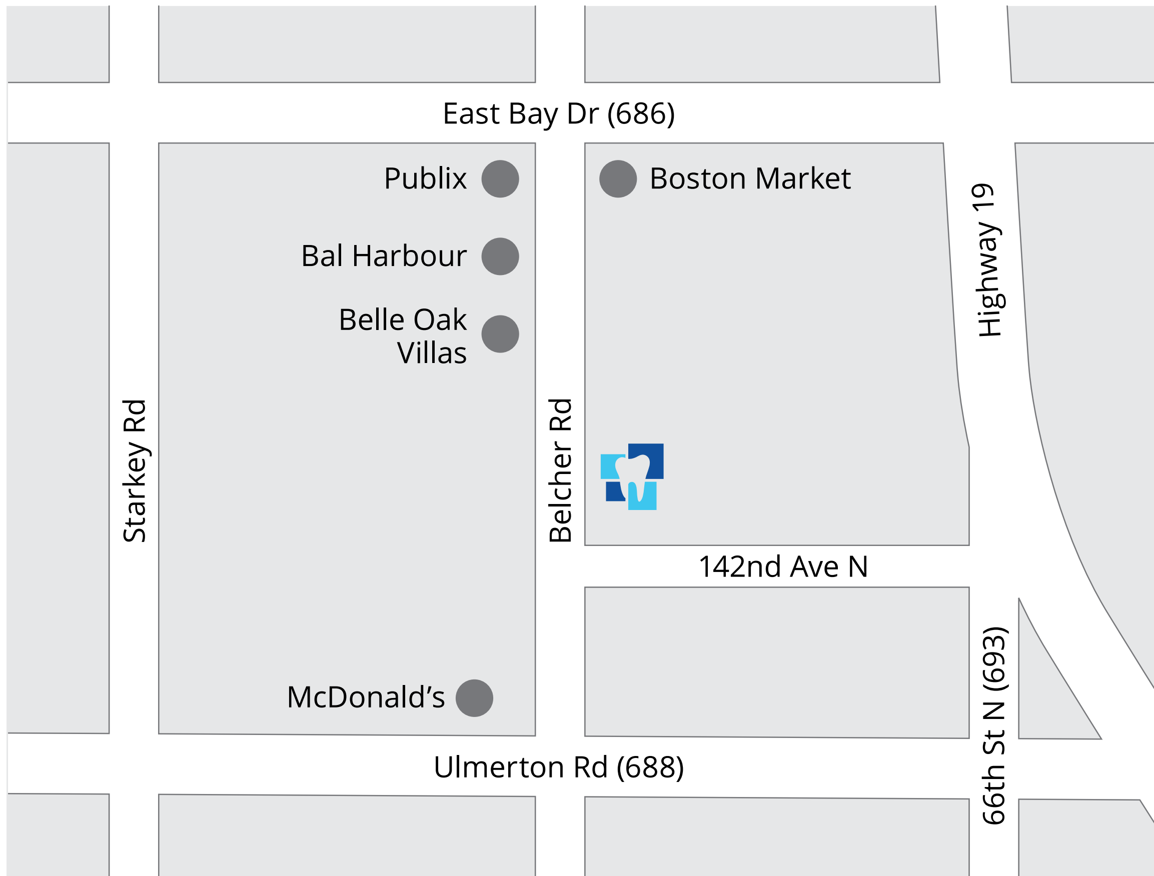
Please

- ☐ Call me before seeing the patient
- ☐ Call me after seeing the patient
- ☐ Alternate recare appointments
- ☐ Do all recare

General Dentist signature: ______________________ **Date:** ______________________

Vanessa Watts, DMD
Board Certified Oral & Maxillofacial Surgeon
Location: Largo Dental One
1475 Belcher Road S, Largo, FL, 33771

Telephone Number: (727) 287-1555
Fax: (727) 290-0589
Email: info@largodentalone.com
Web: Largodentalone.com



Vanessa Watts, DMD
Board Certified Oral & Maxillofacial Surgeon
Location: Largo Dental One
1475 Belcher Road S, Largo, FL, 33771

Telephone Number: (727) 287-1555
Fax: (727) 290-0589
Email: info@largodentalone.com
Web: Largodentalone.com