

# Woodbury Oral Surgery

**Slava Shapiro, D.D.S., M.D., P.C.**

Practice Limited to Oral & Maxillofacial Surgery

Long Island Location  
167 Froehlich Farm Blvd.  
Woodbury, NY 11797  
Tel: 516.677.9777  
Fax: 516.677.9778

Queens Location  
70-09 Austin St., Ste 201, 2<sup>nd</sup> Floor  
Forest Hills, NY 11375  
Tel: 718.261.2790  
Fax: 718.261.2795







## Patient Referral Form

Please bring this form to you appointment.

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Please indicate the teeth or areas to be evaluated:**

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

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> Extractions         | <input type="checkbox"/> I.V. Sedation/Anesthesia |
| <input type="checkbox"/> Apicoectomy | <input type="checkbox"/> Exposure            | <input type="checkbox"/> Implants                 |
| <input type="checkbox"/> Biopsy      | <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> TMJ                      |
| <input type="checkbox"/> Evaluation  | <input type="checkbox"/> Frenectomy          | <input type="checkbox"/> Other: _____             |

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note: If General Anesthesia is to be administered, please DO NOT eat or drinks for six (6) hours prior to appointment and be accompanied by an adult. If you are less than 18 years old, you must be accompanied by a parent or guardian.**