Slava Shapiro, D.D.S., M.D., P.C.
Practice Limited to Oral & Maxillofacial Surgery

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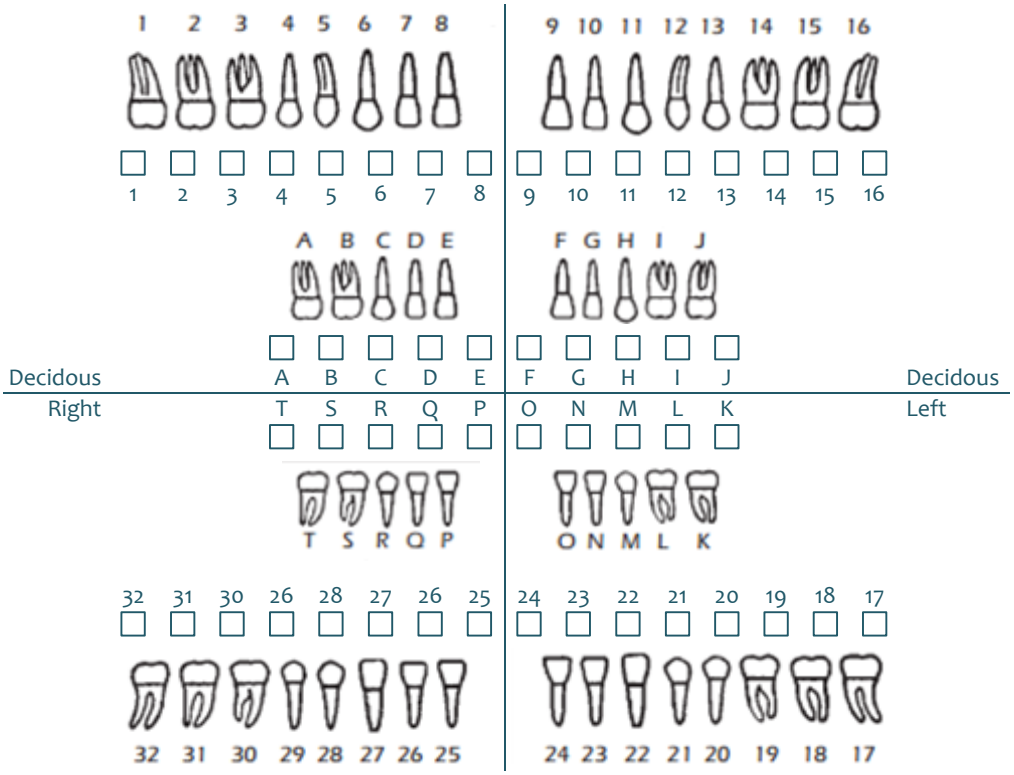
Patient Referral Form

Please bring this form to you appointment.

Date: _____ Patient Name: _____

Referred By: _____ Phone Number: _____

Please indicate the teeth or areas to be evaluated:



☐ Alveoloplasty	☐ Extractions	☐ I.V. Sedation/Anesthesia
☐ Apicoectomy	☐ Exposure	☐ Implants
☐ Biopsy	☐ Incision & Drainage	☐ TMJ
☐ Evaluation	☐ Frenectomy	☐ 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.