Board Certified Oral & Maxillofacial Surgeon

White Birch Oral Surgery

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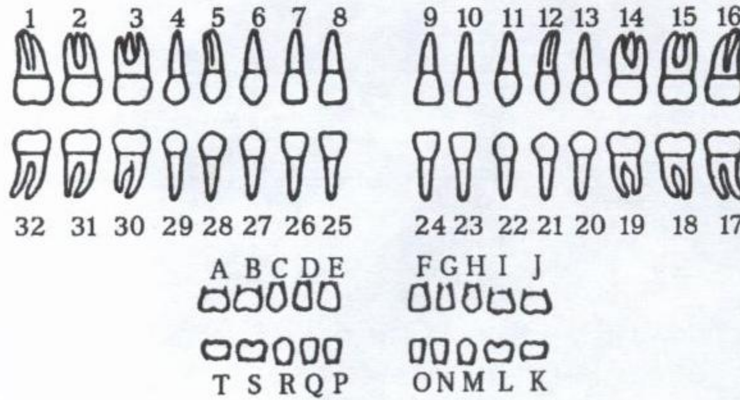
email office@whitebirchoralsurgery.com

Date: ______________________

Patient Name: ______________________

Referring Doctor: ______________________



- ☐ Wisdom Teeth Removal
- ☐ Extraction
- ☐ Jawbone/ Socket Preservation
- ☐ Corrective Jaw Surgery
- ☐ Expose & Bond
- ☐ TMJ/ Facial Pain
- ☐ Other: ______________________
- ☐ Dental Implant Tooth Replacement
- ☐ Pre-prosthetic Therapy
- ☐ Periapical Therapy
- ☐ Bone Grafting
- ☐ Tooth Transplantation
- ☐ Oral Pathology

- ☐ X-Rays needed
- ☐ X-Rays given to patient
- ☐ X-Rays emailed or sent
- ☐ Send copies of X-Rays taken

Comments: ______________________

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Signed: ______________________ Date: ______________________