ORAL MAXILLOFACIAL SURGERY
& DENTAL IMPLANT
CENTER

PATIENT REFERRAL

Telephone: (401) 848-0070
www.rhodeisland-dentalimplants.com
hfxrays@gmail.com

ALEXANDER J. GOMES, D.M.D.
DAVID K. FIASCHETTI, D.D.S.
JOANNE B. CASTANEDA, D.D.S., M.D.
JUDSON DACHER-SHAPIRO, D.M.D.

RTE 114 • 65 West Main Road
Middletown, Rhode Island 02842
across from Ma's Donuts

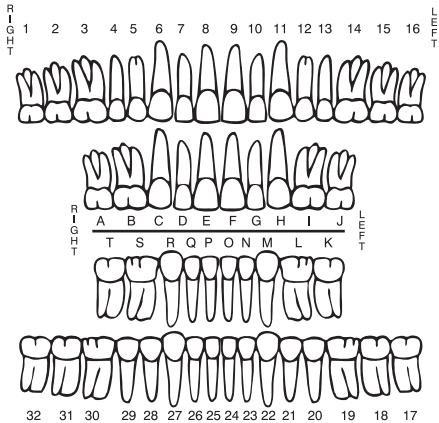
Introducing: _____ Date _____

❑ XRays: None _____Given to Pt _____ E-Mailed _____ Mailed _____

❑ Patient has an appointment on: _____

Treatment Requested: _____

1. Please list and circle teeth to be removed:



2. Consultation:

- ❑ Implants: # _____
- ❑ Apicoectomy: # _____
- ❑ Orthognathic: _____
- ❑ TMJ
- ❑ Sleep Apnea
- ❑ Biopsy/Excision/Oral Cancer Eval.
- ❑ Cone Beam C.T. Scan
- ❑ Other: _____
- ❑ Crown Lengthening
- ❑ 3rd Molar Eval.
- ❑ Gingivoplasty

3. Comments: _____

_____

Doctor: _____

Instructions for patients requiring sedation or general anesthesia:
Nothing to eat or drink 8 hrs. before appointment.
Must bring someone to drive you home.