



GRANT MCGANN, DDS  
ORAL & MAXILLOFACIAL SURGERY

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# PATIENT REFERRAL

Date \_\_\_\_\_ Referring Dr. \_\_\_\_\_

Please take X-ray       Will send X-ray

Please visit our website and complete the patient registration  
Call (858) 874-8181 to schedule your appointment



## PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Patient Name \_\_\_\_\_

Patient Phone \_\_\_\_\_

This patient is being referred for evaluation of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> WISDOM TEETH REMOVAL                          | <input type="checkbox"/> FRENECTOMY                 |
| <input type="checkbox"/> TOOTH EXTRACTION #                            | <input type="checkbox"/> SLEEP APNEA                |
| Reason:  | <input type="checkbox"/> TRAUMA                     |
| <input type="checkbox"/> Decay <input type="checkbox"/> Non-restorable | <input type="checkbox"/> GENIOPLASTY                |
| <input type="checkbox"/> Perio <input type="checkbox"/> Root Fracture  | <input type="checkbox"/> BONE GRAFTING              |
| <input type="checkbox"/> Orthodontic                                   | <input type="checkbox"/> ORTHOGNATHIC EVALUATION    |
| <input type="checkbox"/> DENTAL IMPLANT TOOTH #                        | <input type="checkbox"/> BIOPSY / LESION EVALUATION |
| <input type="checkbox"/> EXPOSURE / BOND TOOTH #                       | <input type="checkbox"/> TEMPORARY ANCHORAGE PLATE  |

COMMENTS:

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