GATEWAY
ORAL & MAXILLOFACIAL SURGERY

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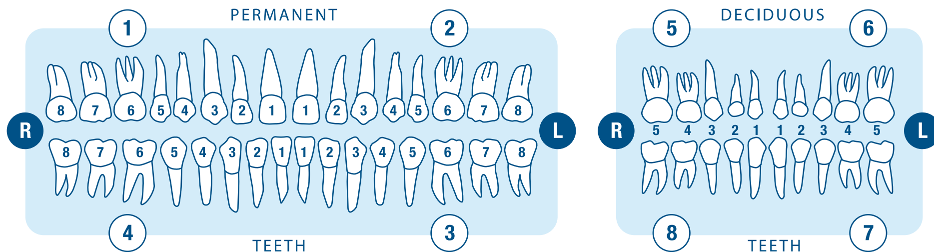
Patient: ______________________ Today's Date: ______________

Telephone: ______________________ Cell: ______________

Appointment: ______________________ Time: ______________ AM/PM

Referred by Doctor: ______________________ Telephone: ______________

PLEASE CIRCLE TEETH TO BE TREATED



PROCEDURES

- ☐ Extraction(s)
- ☐ Dental Implants
- ☐ Bone Grafting
- ☐ Oral Pathology
- ☐ Exposure of teeth
- ☐ Other:

Comments: ____

X-RAYS

- ☐ X-Ray Mailed
- ☐ X-Ray sent with patient
- ☐ X-Ray Emailed
- ☐ Take X-Ray

We prefer that x-rays are emailed if your office uses digital radiography.
Please email to referral@gatewayos.com in a .jpg, .bmp or .tif format .

Referring Doctor Signature: ______________________ Date: ______________