OVALDENTAL
RESTORING & PRESERVING SMILES

VIRGIL VACAREAN, DMD
Advanced Surgical Prosthodontist

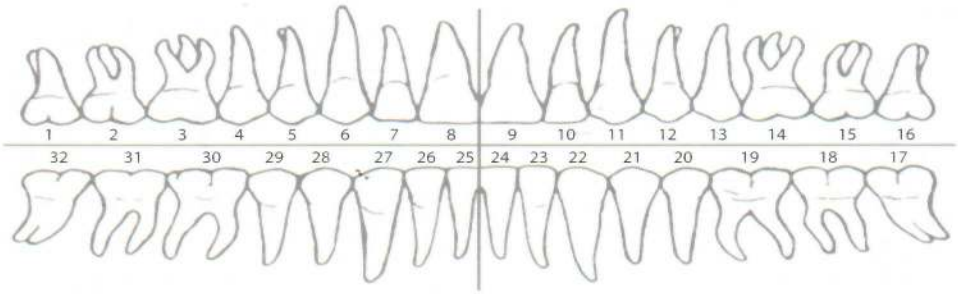
Patient Referral Form

Patient name: _____ Primary phone: _____

Referred by Dr. _____ On: _____ (Date)

Appointment scheduled for: _____ (Date) At: _____ (Time)

Teeth/Area To Be Treated



Oral Surgery

- ❑ Implant Placement
  - ❑ Send Back For Restoration
  - ❑ Restore
- ❑ Alveoloplasty
- ❑ Tori Removal
- ❑ Third Molar Extractions
- ❑ Extraction With Bone Graft
- ❑ Other (please specify)

_____

_____

Prosthodontic

- ❑ Full Mouth Reconstruction
- ❑ Denture or RPD
- ❑ Implant Overdenture
- ❑ Fixed Complete Denture
- ❑ Other (please specify)

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Special Instructions or Comments: _____

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