Oral Surgery Referral

Phone: (916) 368-0440
Fax: (916) 290-0275
E-mail: OS@rcdentalgroup.com

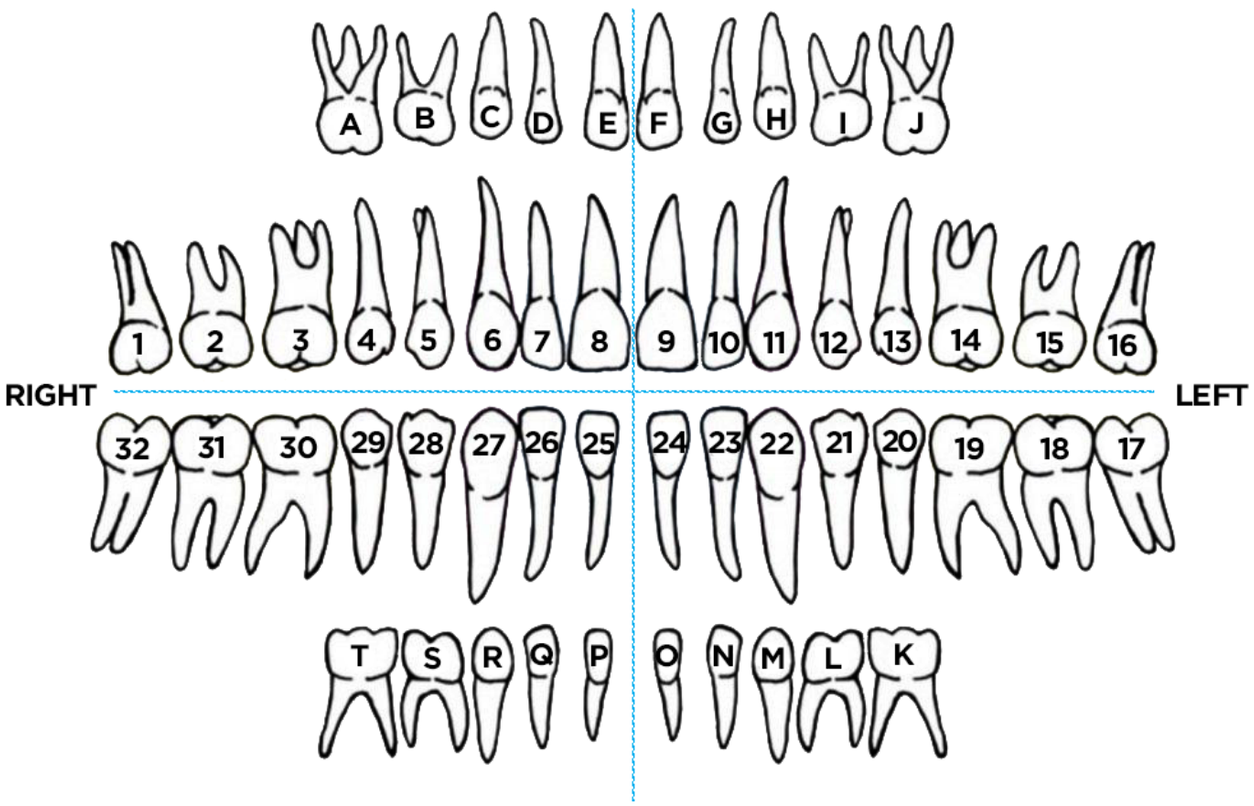
11180 Sun Center Dr
Rancho Cordova, CA 95670

RC Dental GROUP

DATE: _____

REFERRING DOCTOR: _____
First & Last Name

PATIENT NAMe: _____ BIRTH DATE: _____ PHONE #: _____
First & Last Name



Treatment/Reason for Referral

Please Check The Appropriate Infromation

- ◯ Extraction
- ◯ Torus Removal
- ◯ Bone Graft
- ◯ Implant Consultation & Treatment
- ◯ Exposing and Bonding
- ◯ Biopsy
- ◯ Frenectomy
- ◯ Implant Consultation
- ◯ Implant Supported Prosthesis Consult
- ◯ Other _____

Radiopraphs

- ◯ Patient will bring copy
- ◯ I will send

Area to be evaluated:

Referring Dentist's Recommendation:

Results Email

Please return results to this email address

_____

REFERRING DENTIST'S SIGNATURE: _____