

**ORAL FACIAL IMPLANT SURGERY****Drs. Oghalai, Krutoy & Toscano**

Board Certified Oral & Maxillofacial Surgeons

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- ☐ **Mark A. Oghalai, D.D.S.**
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☐ **Corey W. Toscano, D.M.D.**

Today's Date: _____

Patient Name: _____ Patient DOB: _____

Parent/Guardian: _____ Daytime Phone: _____

Appointment Date: _____ Time: _____

Insurance: _____ Insurance ID#: _____

Referring Doctor: _____ Office Phone: _____

Referral Information:

- _____ Consult
_____ Extraction
_____ Other

Radiographs:

(Periapical, Panorex, CBCT)

- _____ Enclosed
_____ Desired
_____ Mailed
_____ Emailed

(xrays@omfsurgeons.com)

Implant Treatment Planning

- _____ Individual Teeth _____
_____ Bridge _____
_____ Full Arch: _____ Maxillary _____ Mandibular
_____ Fixed Hybrid Prosthesis _____
_____ Locator Prosthesis _____

Implant Systems

- _____ Astra Tech EV _____ Nobel Conical Connection

Remarks: _____

**** Please note IF IV Sedation is used: No food or drink 8 hours prior to the appointment, please wear short sleeves or loose clothing; a driver MUST come and STAY in the lobby until the surgery is finished and to drive the patient home afterwards. ****

Please Circle Tooth Number**Right****Permanent Teeth****Left**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary Teeth

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Please refer to our practice website for additional information regarding oral surgical procedures and post-operative information at www.omfsurgeons.com. There are also registration forms that can be printed and completed prior to the appointment.

Maps & Directions on Back of Referral Form