Oral and Maxillofacial Surgery Group Practice
Patient Referral Form

Please fax form to: (617) 638-4365 or email to: osgp@bu.edu

Patient Name:____ Tel:___________________________

Referred by:____ Tel:___________________________

Patient address: ____

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Health Insurance:

Medical ____

Policy # ____

Dental ____

Policy # ____

Referred to (Circle preferences):

	Richard D'Innocenzo, DMD, MD	Pushkar Mehra, BDS, DMD, FACS
Hussam Batal, DMD	Andrew Salama, DDS, MD, FACS	Radhika Chigurupati, DMD, MS
Timothy Osborn, DDS, MD, FACS	Steven Caldroney, DDS, MD, FRCS	Ruben Figueroa, DMD, MS
Bradford Towne, DMD	Steven Bookless, DDS, MBA	Any of above doctors

Reason for Referral

Implants/ Grafting: ____

Pathology- Area/ Location: ____

TMJ Dysfunction: ____

Orthognathic Surgery: ____

Cosmetic Surgery: ____

Preprosthetic Surgery: ____

Sleep apnea/ Snoring: ____

Head and Neck Cancer: ____

Nerve Injury: ____

Cleft Lip and Palate: ____

Reconstruction Surgery: ____

Facial Trauma: ____

Other: ____

Dentoalveolar Surgery:
Procedure: ____ Extraction of teeth ____ Surgical exposure of teeth

Please write teeth number(s) in addition to circling teeth

Teeth: ____

R	PEDO				41	42	43	44	45	46	47	48	49	50				L
I					E	D	C	B	A	A	B	C	D	E				E
G																		F
H	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		T
T	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
	PEDO				E	D	C	B	A	A	B	C	D	E				
					60	59	58	57	56	55	54	53	52	51				

____ Please call patient for appointment ____ Patient will call for appointment

____ X-rays enclosed ____ Patient has X-rays ____ No X-ray

Comments:

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