Captain Dental

Oral Surgery Referral Form

4585 Stevens Creek Blvd, Ste 101, Santa Clara , CA, 95051

Tel # 408-826-4676 www.captaindental.com

INTRODUCING: ______________________________

patient name *date of birth*

Treating Tooth or Area(s)

				A	B	C	D	E	F	G	H	I	J				
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
R	32	31	30	29	28	27	26	25	24	23	22	21	20	19	28	17	L
				T	S	R	Q	P	O	N	M	L	K				

Reason for Referral

- ☐ Consultation
- ☐ Extraction
- ☐ Wisdom Teeth
- ☐ Implants
- ☐ IV Sedation
- ☐ Bone Grafting
- ☐ Pathology / Biopsy
- ☐ All-on-4's
- ☐ Expose & Bond
- ☐ Botox
- ☐ Temporomandibular Joint Dysfunction

Special Instructions: ______________________________

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Panoramic Radiographs

- ☐ Emailed: frontdesk.sc@captaindental.com
- ☐ Given to Patient
- ☐ Please Take

Referring Doctor: ______________________________

name *date*

Referring Clinic: ______________ ______________

phone number *email address*

INSTRUCTIONS TO PATIENT

- Please **give the slip to the doctor** at the time of your consultation or surgery appointment.
- Minors (under 18 years) must be accompanied by parent or guardian or have written consent for operation.
- If you are going to have a general anesthetic, **do not eat or drink anything** for 6 hours before your appointment.
- Bring someone to drive you home if you are going to have premedication or a general anesthetic.
- Wear comfortable and loose fitting clothing, short sleeves are preferable.
- Please bring with you the name of the medications you are taking, or those to which you are allergic.
- Please call this office if you have had rheumatic fever, diabetes, heart murmur, artificial valve or joints.