DR. HARINDER LOTAY
ORAL & MAXILLOFACIAL SURGERY
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RIDGE MEADOWS

Date:_____

Patient Name:_____

Phone:_____ M ☐ F ☐ DOB: _____ (m d y)

Primary Ins Co:_____ Policy #:_____ ID#: _____

Secondary Ins Policy Holder Name: _____ DOB: _____ (m d y)

Secondary Ins Co:_____ Policy #:_____ ID#: _____

Medical Concerns:

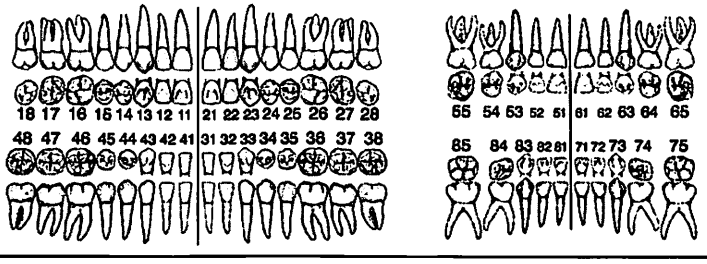
Consultation Regarding:

☐ Extractions ☐ Implants Transitional denture arranged? Y____N____

☐ TMJ ☐ Pathology ☐ CT scan ☐ Bone Graft ☐ Exposure

☐ Other (please specify):_____

PLEASE INDICATE TEETH TO BE REMOVED WITH AN X.



☐ Routine ☐ Urgent

Radiographs : ☐ Emailed ☐ None

Referring Doctor: _____ Phone number:_____

Send more referral forms: ☐

PLEASE SEE REVERSE SIDE FOR LOCATION MAP ➡

NOTES:

- ACCEPTED METHODS OF PAYMENTS: VISA, MASTERCARD, DEBIT, CASH NO CHEQUES PLEASE!