THREE RIVERS
Oral & Maxillofacial Surgery

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REFERRAL / EVALUATION OF:

Name _____

Appointment Date /Time _____

❒ Extraction or Surgical Removal

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

❒ Orthognathic Surgery ❒ Pre-prosthetic Surgery

Date _____

❒ Implants ❒ Osseous Pathology

❒ Infection ❒ TMJ

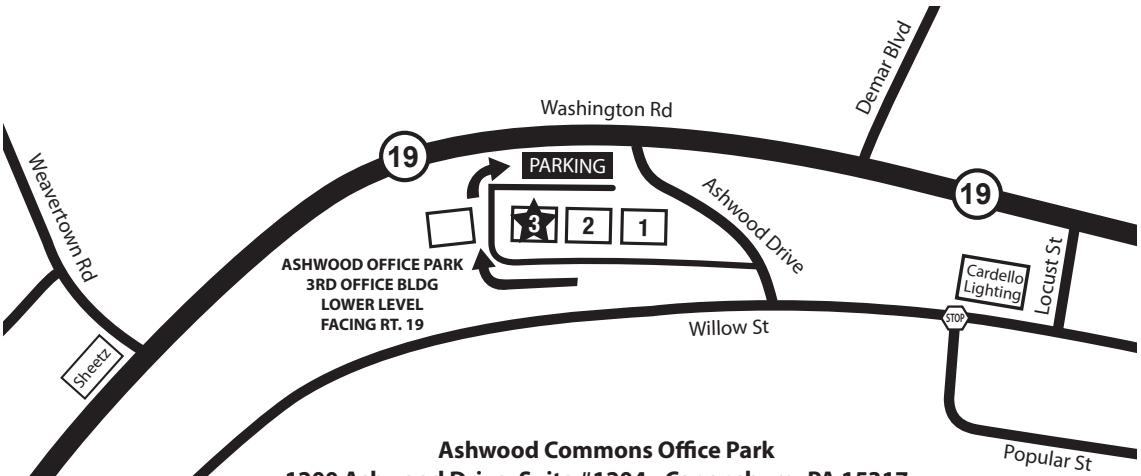
❒ Soft Tissue Pathology ❒ Other

Remarks:

_____
(Signed) Referring Doctor

Please bring this Referral Card with you for your initial Consultation to ensure proper treatment planning.

CANONSBURG OFFICE



Ashwood Commons Office Park
1200 Ashwood Drive, Suite #1204 • Canonsburg, PA 15317
Please drive to lower level parking lot facing Rt. 19

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