UKIAH
ORAL SURGERY & DENTAL IMPLANTS

Adam Wandell, DDS, MD
James Lelis, DDS, MD

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT PHONE _____

PATIENT EMAIL _____

REFERRING DOCTOR _____ PHONE _____

REFERRAL EMAIL _____

REFERRING DOCTOR SIGNATURE _____ TODAY'S DATE _____

REASON FOR REFERRAL: _____

○ THIRD MOLARS ○ EXTRACTION ○ DENTAL IMPLANT

○ EXPOSURE + BOND ○ ALL-ON-X MAXILLA ○ ALL-ON-X MANDIBLE

○ PREFERRED IMPLANT SYSTEM _____

RECENT X-RAYS

○ SENT WITH PATIENT ○ MAILED ○ EMAILED ○ PLEASE TAKE XRAYS

IF SENT, TYPE: ○ PANOREX ○ PERIAPICAL ○ CBCT ○ DATE TAKEN _____

AREA (s) TO BE EVALUATED

UPPER RIGHT										UPPER LEFT
			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	O	P	O	N	M	L	K			
LOWER RIGHT															LOWER LEFT

ADDITIONAL COMMENTS

Select provider (if preferred) ☐ DR. WANDELL ☐ DR. LELIS

Radiographs and referral slips can be emailed to info@healdsburgoralsurgery.com. All patients are encouraged to complete their patient registration forms prior to their appointment by visiting our website at healdsburgoralsurgery.com