Dr. Lee Darichuk, BSc DMD MDent FRCDC - Oral & Maxillofacial Surgeon

Date: ____________ Patient Name: ____

Patient Cell: __________________ Patient Email: ________________________________

Patient Birth Date: _____/____/_______ Patient Other Phone: ______________________
(DD)/(MM)/(YYYY)

Patient Insurance Info: ____

Referring Doctor: ______________________ Doctor Phone: _____________________

Reason for Referral:

☐ Third Molars ☐ Dental Extraction(s) ☐ Bone Augmentation

☐ Implant(s), Brand/Location: ___________________________, ☐ Guided Surgery

☐ Tooth exposure ☐ Pathology / Biopsy ☐ Orthodontic Implant

☐ Temporomandibular Joint Disorder

☐ Post-Surgical Assistance ☐ Sedation / General Anesthesia

Teeth to be extracted:															
			55	54	53	52	51	61	62	63	64	65			
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			85	84	83	82	81	71	72	73	74	75			
99 - Supernumerary, Qty:								Other:							

Radiographs: ☐ Mailed ☐ E-mailed ☐ Enclosed ☐ With Patient ☐ Please obtain

Notes: ____

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Medical Alert:____

Signature:____

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