Doctor Referral Form

Westwood Family Dentistry
3823 Eighth Ave San Diego CA 92103
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Fax: (619) 704-3332
Email: contact@docwestwood.com
www.docwestwood.com

Date: _____

Patient Name: _____

Date of Birth: _____

PLEASE CIRCLE TEETH TO BE TREATED

			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			

Reason for Referral:

❑ Extraction ❑ Implant Consultation ❑ Orthognathic Surgery

❑ TMJ Consultation Evaluation ❑ Apicoectomy ❑ Preprosthetic Surgery

❑ Expose & Bond ❑ Bone Grafting ❑ Sinus Augmentation

❑ Biopsy/Pathology ❑ Crown Lengthening ❑ Incision and Drainage of Abscess

❑ Ortho-consult ❑Root Canal treatment/re-treatment

❑ Other: _____

_____

_____

RADIOGRAPHS

❑ None Available ❑ Given to the Patient ❑ Will be emailed

Remarks/Special Instructions: _____

_____

❑ **Special Needs** ❑ **Nitrous** ❑ **General Anesthesia**