Niguel Coast
ORAL & FACIAL SURGERY

Mary Delsol, DDS ☐
Eric Baker DDS, MD ☐
Oral & Maxillofacial Surgery

Referral Form

Introducing:_______________________________ Date:______

Patient Phone: __________________ Email: ________________

Teeth #/Area of treatment:_________________

Proposed Treatment: ☐ Dental Implants ☐ Wisdom Teeth

☐ Extractions: *Discuss Implants? Yes __ No__* ☐ Bone Grafting

☐ All-on-4 ☐ Biopsy

☐ Orthognathic Surgery ☐ Nerve Microsurgery

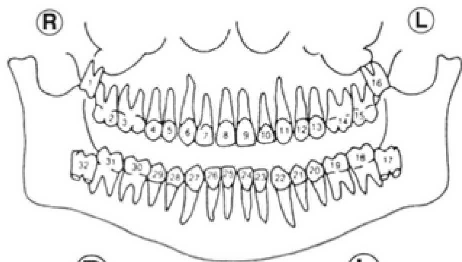
☐ Sleep Apnea ☐ Expose/Bond

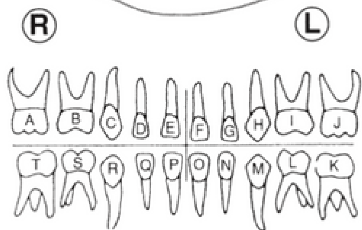
☐ TMJ Evaluation ☐ Soft Tissue Grafting

☐ Other (specify)

Specifics:____

PLEASE CIRCLE TEETH / AREA TO BE TREATED





Radiographs:

☐ Emailed/Enclosed

☐ Take New Radiographs

☐ CBCT Requested

Management/Medical/Treatment Concerns:_____________________________
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☐ **Call before starting treatment**

Referred by Doctor:___________________________ **(please FAX to: 949-240-2619)**

☐ Send more referral slips