

Scott M. Redlinger, DMD, MD

## PATIENT REFERRAL

Referring Dentist or Physician	Date
Address	
Telephone	
Patient	Patient Contact Number

- For:  CONSULTATION  
 REMOVE THE FOLLOWING TEETH:

	A	B	C	D	E	F	G	H	I	J							
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	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							

**APPOINTMENT:**  Patient to make directly.

A special time has been reserved for this patient:

Day	Date	Time
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### IMAGING STUDIES

- X-Rays:  w/Patient  Mailed  
 Please take new Panoramic Radiograph  
 Please take new Periapical Radiograph

- Other procedures/treatments - please list below.  
 Anesthesia preference:  
 Local  Nitrous Oxide  General Anesthesia

\*Please remove earrings or piercings prior to appointment if x-rays are to be taken.

Remarks / **Medical Alerts:**

**Please list below, requests for additional or special PROCEDURES or TREATMENTS. Thank You.**

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**Call for appointment: (775) 853-9696**  
**Please see map on back of form for location**