RENO RT TAHOE

Oral Surgery & Dental Implant Center

Scott M. Redlinger, DMD, MD

PATIENT REFERRAL

Referring Dentist or Physician _______________ Date _______

Address _______________

Telephone _______________

Patient _______________ Patient Contact Number _______________

APPOINTMENT: ❒ Patient to make directly.

A special time has been reserved for this patient:

Day _______ Date _______ Time _______

IMAGING STUDIES

X-Rays: ❒ w/Patient ❒ Mailed

❒ Please take new Panoramic Radiograph

❒ Please take new Periapical Radiograph

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

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				

❒ Other procedures/treatments - please list below.

Anesthesia preference:

❒ **Local** ❒ **Nitrous Oxide** ❒ **General Anesthesia**

❒ Remarks / **Medical Alerts:**

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

Call for appointment: (775) 853-9696

Please see map on back of form for location

5420 Kietzke Lane, Suite 102, Reno, Nevada 89511 ph: (775) 853.9696 fx: (775) 853.9695