TRIANGLE IMPLANT CENTER
DENTAL IMPLANTS & ORAL AND MAXILLOFACIAL SURGERY

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2300 Wayne Memorial Dr.
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Referring Clinician _____ Date _____

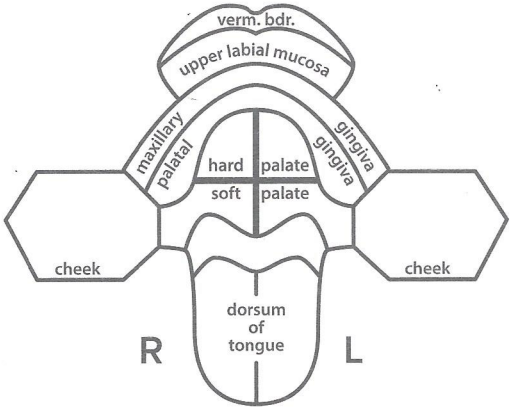
Phone _____ Fax _____ Email _____

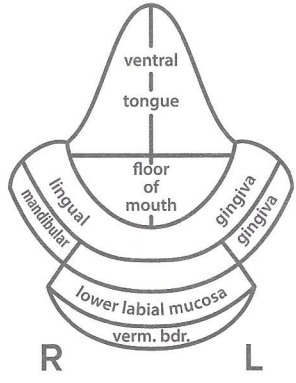
Patient Name _____ Phone _____

Appointment Time _____

Chief Complaint _____

ORAL EXAMINATION FINDINGS Briefly describe lesion character, color, and location. Use mouth diagram below if necessary.





Thank you for referring your patient to Triangle Implant Center. Please attach any pertinent biopsy and/or clinical laboratory report, and radiograph. Also, ask patient to bring his/her dental insurance.

You may also fax the documentation to _____ or email _____ prior to the appointment.

Patients are ALWAYS seen for an initial consultation before any surgical procedures are scheduled.