REQUEST FOR ORAL SURGERY CONSULTATION

Oral and Maxillofacial Surgeon - Denis Nagy, B.Sc., M.Sc., D.D.S., M.D., F.R.C.D.(C) - Dr. Denis Nagy Inc.

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email / fax / mail / referrals accepted

Thank you for your referral

REFERRING DOCTOR:

• **DATE OF REFERRAL**

Practice Name & Contact information:

PATIENT INFORMATION

Patient NAME please c : Mr. Mrs. Ms. Master Miss

Guardian Name

(first) **(middle)** **(last)**

Patient DOB: (month / day / year)

Address

(street) (city / prov) (postal code)

Contacting

(home telephone) (cellular)

EMAIL ADDRESS *required*

INSURANCE INFORMATION (include dual coverage)

No Insurance

1ST Carrier		**2ND Carrier**	
Insured Name		Insured Name	
Insured Birthdate		Insured Birthdate	
Employer		Employer	
Group No.		Group No.	
I.D. No.		I.D. No.	
Dependant No.	% of Coverage	Dependant No.	% of Coverage

REASON FOR REFERRAL

X-Rays Enclosed / sending

No X-Rays available

Take X-Ray : Panorex 3D imaging

Duplicate X-Ray for DDS

- Wisdom Teeth Extraction
- Extraction of Teeth
- Pathology
- Bone Grafting
- Preprosthetic surgery
- Other (please comment)

18	**17**	**16**	**15**	**14**	**13**	**12**	**11**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**
48	**47**	**46**	**45**	**44**	**43**	**42**	**41**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**
			55	**54**	**53**	**52**	**51**	**61**	**62**	**63**	**64**	**65**			
			85	**84**	**83**	**82**	**81**	**71**	**72**	**73**	**74**	**75**			

** Please make sure you have provided ALL information requested. Missing information may delay processing referral **

We triage referrals & contact patients in the order we receive them ** Thank you **

COMMENTS and ADDITIONAL INFORMATION

• we recommend you make a copy of this form for your records

•Report Requested: YES NO

form last updated 9/29/2022