ATLANTIC
Oral Surgery & Facial Reconstruction Centres
NEWFOUNDLAND

DATE _____

PATIENT NAME (Last) _____ (First) _____ D.O.B. _____

Street Address _____ City _____

Province _____ Postal Code _____ Gender: ☐ M ☐ F ☐ X

Telephone (Home) ( ) _____ (Cell/Work) ( ) _____ Email _____

MCP # _____ Parent/Guardian (Last) _____ (First) _____

LOCATIONS *(Please indicate preference of location for your patient)* / SURGEON

☐ NFLD (Gander) ☐ DARTMOUTH	*Louis A. Bourget*

APPOINTMENT ☐ ASAP ☐ ELECTIVE

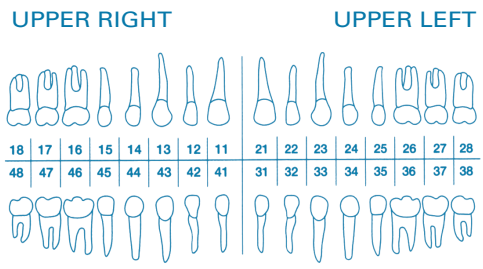
X-RAYS ☐ PLEASE TAKE ☐ Attached (PAN or PA only) DATE TAKEN: _____

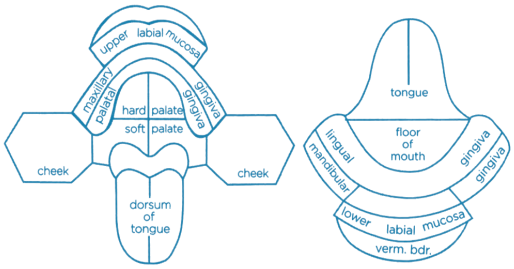
REFERRING DOCTOR (Last Name) _____ (First) _____

Telephone ( ) _____ Fax ( ) _____ Email _____

REASON FOR REFERRAL

☐ Implants _____
☐ Extractions _____
(Please indicate on chart to the right)
☐ Expos & Bond
☐ Orthognathic Surgery
☐ TMD/Oro-Facial Pain
☐ Pathology
☐ CBCT





PLEASE MARK ABOVE THE EXACT SITE OF THE BIOPSY

MEDICAL HISTORY or MEDICATIONS OF NOTE _____

NOTES:

Atlantic Oral Surgery & Facial Reconstruction Centres

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