FACE2FACE
Maxillofacial Surgery Centre

19838 S. Halsted Street | Chicago Heights, IL 60411
(708) 755-0800
www.face2facesurgery.com

Patient Referral Form

PATIENT NAME: ______________________________ **DATE:** ____________

REFERRING DOCTOR: ______________________________

REASON FOR REFERRAL: ______________________________

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

____ **Consultation**

____ **Extraction**

____ **Wisdom Teeth**

____ **Bone Grafting**

____ **Biopsy**

____ **Exposure and Bonding**

____ **IV Sedation/Anesthesia**

____ **Botox/Facial Fillers/Kybella**

____ **Pre-Prosthetic Surgery**

____ **TMJ Problems**

____ **Dental Implants**

____ **X-rays given to patient**

PATIENT INSTRUCTIONS

1. If sedation is requested please bring a responsible adult with you to drive you home. No food or liquid including water by mouth 8 hours prior to your appointment
2. Please bring referral slip at time of appointment and any available x-rays
3. Please bring all medical and dental insurance information with you
4. Bring a list of all medications taken daily
5. 48 hours notice is required for all appointment cancellations