Julia H. Townsend, DDS

Oral & Maxillofacial Surgery, Implants,
Trauma, Reconstructive Surgery

Diplomate, American Board of Oral and Maxillofacial Surgeons

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Introducing _____

Age _____ Patient's Phone (___)_____

Referred by _____ Date _____

Reason for Referral: _____

☐ EXTRACTION(S) ☐ IMPLANT TREATMENT

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

	A	B	C	D	E	F	G	H	I	J	
R											L
	T	S	R	Q	P	O	N	M	L	K	

Anesthesia Preferred:

☐ General/I.V. Anesthsia

☐ Local Anesthesia

☐ Panoramic Radiograph Enclosed

☐ Periapical Radiograph Enclosed

☐ Please Take Appropriate Radiograph

COMMENTS:

_____

_____

_____

_____

APPOINTMENT INFORMATION

This time is reserved for you. The consultation appointment is to discuss your health and the indicated surgery, as well as to appoint your surgery. If for any reason the consultation or surgical appointment cannot be kept, kindly notify us one day in advance.

Day_____ Date _____ Time _____

☐ Please send additional referral slips.