



PROGRESSIVE ORAL SURGERY
& IMPLANTOLOGY OF LONG ISLAND

Referral Form

Patient Information

Patient Name:	Date of Birth:
Phone / Email:	
Date of Last PAN (if applicable):	Sending? <input type="checkbox"/> Yes <input type="checkbox"/> No

Referring Provider

Provider Name:	Practice Name:
Phone / Email:	Date of Referral:
Prepared By (staff member completing this form):	

Contact & Urgency

Preferred Contact: Phone Email

Urgency: Routine Emergency

Patient should first be seen for: Consultation Emergency Surgery

Reason for Referral

Extraction(s): _____ Dental Implants: _____ Bone Grafting: _____
 Apicoectomy: _____ CT Cone Beam: _____ TMJ / Orofacial Pain: _____
 Incision and Drainage: _____ Expose & Bond: _____ Sinus Augmentation: _____
 Pathology / Biopsy (area): _____ All-on-X Implant Evaluation: _____

Other: _____

Remarks:

Teeth #'s 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
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 T S R Q P O N M L K

Authorization

I confirm the above information is accurate.

Signature: _____ Date: _____

23 BOND STREET – GREAT NECK, NY 11021 – T. 516-482-0329 F. 516-482-0401
 601 FRANKLIN AVE, STE 110- GARDEN CITY, NY 11530 -T. 516-741-4415 F. 516-741-4417
 2035 LAKEVILLE RD STE 301, NEW HYDE PARK, NY 11040 – T. 516-437-2666 F.516-358-6954
 400 S OYSTER BAY ROAD STE 104, HICKSVILLE, NY 11040 - T. 516-735-7800 F. 516-390-7196

Thank you for trusting Progressive Oral Surgery with your patient's care