Laguna Surgical & Cosmetic Specialists

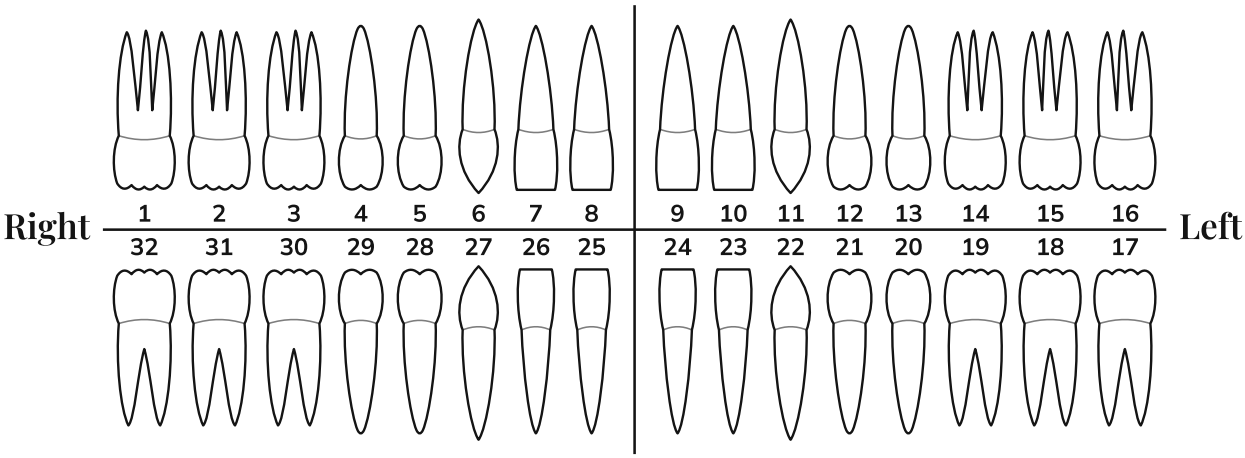
Arthur Johnson III, MD, DDS
ORAL & MAXILLOFACIAL SURGERY

Patient Referral Form

Patient Name _____

Day Phone _____ Bringing X-ray? ☐ Yes ☐ No

Appointment Date _____ Time _____ Tooth # _____



Circle the tooth or teeth involved.

Procedure(s) Referred For

☐ Extraction(s) ☐ Alveoplasty ☐ Biopsy / Lesion

☐ Implant ☐ Bone Grafting ☐ Tooth Exposure / Ortho

☐ Frenectomy ☐ Hospital Case ☐ 3D Cone Beam CT Scan

Other / Notes _____

☐ General Anesthesia / IV * ☐ Nitrous Oxide Sedation

* If you are scheduled for IV sedation, do not eat or drink **anything** 8 hours prior to surgery. Wear loose, comfortable clothing, and you **must** be accompanied by a driver.

Referring Doctor _____ Telephone _____

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