village pointe
ORAL SURGERY
& DENTAL IMPLANT CENTER

Patient's Name: _____ **Date:** MM / DD / YYYY

Patient's Phone: _____ **Referred By:** _____

Referral Appointment

Date: MM / DD / YYYY ☐ AM

Time: _____ ☐ PM

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri

- ☐ Appointment has been made
- ☐ Patient will call for an appointment
- ☐ Please call the patient

This time is reserved specifically for you. If by necessity, you must cancel your appointment for surgery please notify us at least one day / 24 hours in advance.

You can save time by going online! Register and update your health history today at WWW.VPOMS.COM

PROCEDURE

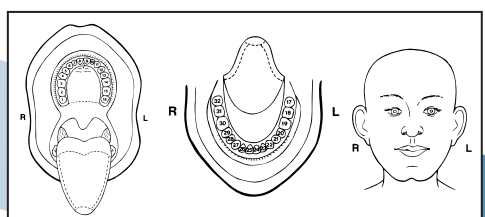
- ☐ Extraction
- ☐ Implants
- ☐ Bone Grafting
- ☐ Exposure and bonding
- ☐ Biopsy (Soft or Hard Tissue)
- ☐ Lesion Evaluation
- ☐ Infection (I&D)
- ☐ Alveoloplasty
- ☐ Frenectomy
- ☐ Other _____
- ☐ CT Evaluation - Please list site of interest and / or purpose for imaging

X-RAYS

- ☐ Being Mailed/Emailed
- ☐ Given to the Patient
- ☐ Please take
- ☐ Other

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15	☐ 16
☐ 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
☐ T	☐ S	☐ R	☐ Q	☐ P	☐ O	☐ N	☐ M	☐ L	☐ K



ADDITIONAL COMMENTS

Please turn over and read IMPORTANT PATIENT INFORMATION

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