The Health Center Oral Surgery Referral Form

P.O. Box 320, 157 Towne Ave., Plainfield VT 05667
Email: Oral.Surgery@the-health-center.org
Phone: (802) 322-0702 **Fax:** (802) 322-3462

PLEASE EMAIL REFERRAL, MEDICAL HISTORY, AND X-RAYS.
HAVE PATIENT CALL TO SCHEDULE.

Oral Surgery: Clark Andelin, DMD, MD **IV Sedation, Extractions:** Andrew LePine, DDS

Referring Dentist:

Referring Office: _____ Date: _____

Telephone: _____ Fax: _____

Patient Information:
Patients must be 15 years old or older

Name: _____ DOB: _____Sex: F M

Telephone: _____ Address: _____

Insurance Company:_____ID#: _____

If Minor, Guardian Name: _____

PERMANENT:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

RIGHT LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

DECIDUOUS:

A B C D E F G H I J

T S R Q P O N M L K

PROCEDURE REQUEST:

REMARKS: _____

[ ] X-Ray Enclosed Date Taken: _____ **[ ] IV Sedation Requested**
[ ] X-Ray To Be Taken **[ ] Local Anesthesia Only**

*****PLEASE CALL 802-322-0702 TO SCHEDULE YOUR ORAL SURGERY APPOINTMENT*****

2024.10.16