Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Oral Surgery Group Practice
Patient Referral Form

Please fax form to: (617) 638-4365 or email to: osgp@bu.edu

Patient Name:_____ Tel:_____

Referred by:_____ Tel:_____

Patient address: _____

_____

Health Insurance:

Medical _____

Policy # _____

Dental _____

Policy # _____

Referred to (Circle preferences):

Hussam Batal, DMD | Radhika Chigurupati | Pushkar Mehra, BDS, DMD

Timothy Osborn, DDS, MD | Andrew Salama, DDS, MD | Any of above doctors

Reason for Referral

Implants/ Grafting: _____

Pathology- Area/ Location:_____

TMJ Dysfunction: _____

Orthognathic Surgery: _____

Cosmetic Surgery: _____

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Preprosthetic Surgery: _____

Sleep apnea/ Snoring: _____

Head and Neck Cancer: _____

Nerve Injury: _____

Cleft Lip and Palate: _____

Reconstruction Surgery: _____

Facial Trauma: _____

Other: _____

Dentoalveolar Surgery:

Procedure: ____ Extraction of teeth ____ Surgical exposure of teeth

Please write teeth number(s) in addition to circling teeth

Teeth: _____

R	PEDO					41	42	43	44	45	46	47	48	49	50		L
I						E	D	C	B	A	A	B	C	D	E		E
G																	F
H	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	T
T	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

PEDO	E	D	C	B	A	A	B	C	D	E
	60	59	58	57	56	55	54	53	52	51

____ Please call patient for appointment ____ Patient will call for appointment

____ X-rays enclosed ____ Patient has X-rays ____ No X-ray

Comments:

_____

_____

_____

_____