MIDTOWN ORAL & MAXILLOFACIAL SURGERY

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Board Certified, American Board of Oral & Maxillofacial Surgery

❒ **Dr. Casmedes** ❒ **Dr. Jenkins** ❒ **Dr. Tibbitts** ❒ **Dr. McFarling**

Date / / D.O.B / /

Patient Name _____ Ph# _____

Referring Doctor _____ Ph# _____

☐ **URGENT: Please call our office to discuss if this is urgent.**

- ☐ Orthognathic Surgery
- ☐ Genioplasty
- ☐ Implant _____
- ☐ Pathology - location _____
- ☐ Frenectomy
- ☐ Temporomandibular Joint Disorder
- ☐ Extraction of indicated teeth (marked with an "x" on the diagram below)
- ☐ Surgical exposure/uprighting of the following impacted teeth (circle teeth):
- ☐ Surgical exposure / Bonding to following impacted teeth

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

RIGHT	A	B	C	D	E	F	G	H	I	J	LEFT
	T	S	R	Q	P	O	N	M	L	K	

Please allow our office 48 hours to process the referral and reach out to the patient for scheduling.
Please send referral and any pertinent documentation to **patientinfo@midtownomsatx.com**

Other/Referral Comments _____

_____

_____

Referring Dr. Signature _____

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