



trillium

ORAL SURGERY AND IMPLANTOLOGY

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Patient Name: _____

Please mark tooth/teeth below:

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

- Extraction(s) Implant(s) Pre-Prosthetic Orthognathic
 Pathology TMJ Bone Grafting Soft Tissue Grafting
 Other _____

Future Treatment Planned: _____

Radiographs: Required Attached Emailed (frontdesk@trilliumoralsurgery.com)
 Sent via website Date of Radiographs: _____

INSTRUCTIONS TO PATIENTS:

- **BRING THIS REFERRAL FORM (and any x-rays you were given) TO YOUR APPOINTMENT.**
- Please complete patient registration forms at www.trilliumoralsurgery.com prior to your appointment.
- **GENERAL ANESTHESIA (SLEEP) INSTRUCTIONS:** No food or liquid should be taken for six hours before your scheduled appointment. A responsible adult is required to accompany patient and drive patient home.
- Minors must be accompanied by a parent or legal guardian.

Referred by: Dr. _____ Date: _____

www.trilliumoralsurgery.com