



# trillium

ORAL SURGERY AND IMPLANTOLOGY

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### Chelsea Office:

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Chelsea, MI 48118  
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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](http://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](http://www.trilliumoralsurgery.com)