

REFERRAL FORM

Commonwealth oral & facial surgery

Referred by Dentists | Preferred by Patients

Information & Appointments
(804) 354-1600
Email: referrals@commonwealthofs.com

Patient Name: _____ DOB ___/___/___ Sex: Male Female

Phone Number: _____ Email: _____

Appointment Date: _____ Time: _____

Referring Doctor: Thank you for your referral. Please fill out this form and submit online, email or send with patient.

Referred by: _____ Date: _____

Practice Name: _____ Address/Location: _____ (if multiple offices)

Phone: _____ Email: _____

Patient to See:

- Dr. Mike Miller Dr. Greg Zoghby Dr. Jeff Cyr Dr. Drew Ferguson Dr. Ammar Sarraf
 Dr. Charlie Boxx Dr. Lauren Kaplan Dr. Nick Broccoli Dr. Sean Eccles First Available

Office Locations:

- | | | | | | |
|---|---|--|--|--|--|
| <input type="checkbox"/> Brandermill
5942 Harbour Park Dr.
Midlothian, VA 23112 | <input type="checkbox"/> Chester
12220 Iron Bridge Rd.
Suite B
Chester, VA 23831 | <input type="checkbox"/> Mechanicsville
7009 Lee Park Rd.
Mechanicsville, VA 23111 | <input type="checkbox"/> Midlothian/ Bon Air
1807 Huguenot Rd.
Suite 120
Midlothian, VA 23113 | <input type="checkbox"/> Patterson
@Parham Road
8503 Patterson Ave., #A
Henrico, VA 23229 | <input type="checkbox"/> Westerre Commons
near Broad & Cox
3811 Westerre Pkwy, #A
Henrico, VA 23233 |
|---|---|--|--|--|--|

Please verify teeth for treatment (check boxes):

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LEFT
		A	B	C	D	E	F	G	H	I	J						
RIGHT		T	S	R	Q	P	O	N	M	L	K						LEFT

Oral Surgery Procedure:

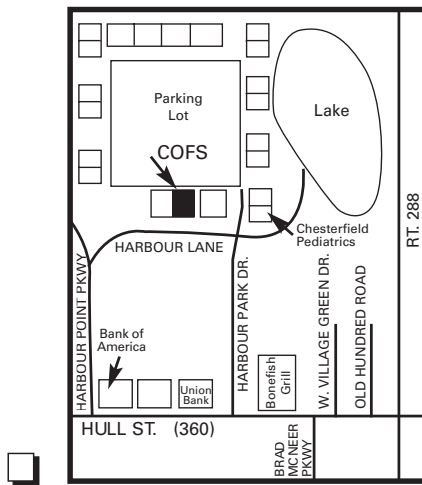
- Wisdom Teeth
- Extraction(s), teeth# _____
- With Socket Grafting With Immediate Implant
- Dental Implant(s), teeth # _____
- Implant Preference: _____
- Intraoral Scan
- Full Arch Implant Evaluation
- Biopsy Apicoectomy Frenectomy
- Exposure Bracket, teeth # _____
- Orthognathic Evaluation TMJ Evaluation
- Other/Comments: _____

Radiographs: As providers of oral & maxillofacial surgery, we take our own x-rays on every patient for diagnostic purposes and treatment planning. COFS will provide a copy of x-rays, if requested below. If needed for diagnostics, our team may request any past x-rays.

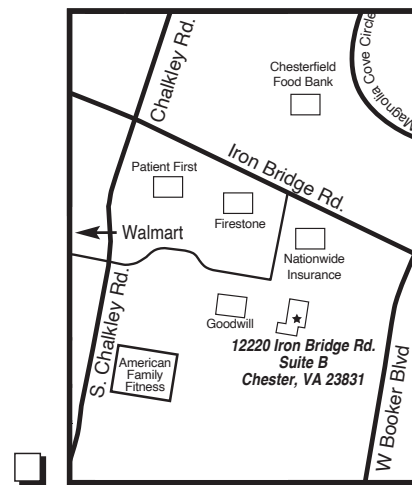
- Please provide the date taken of most recent x-rays.
*Panorex Date: _____
*PA Date: _____ Tooth #: _____
*Cone Beam CT Scan Date: _____
- X-ray emailed to referrals@commonwealthofs.com (OPTIONAL)
- Please send/forward copy of COFS x-ray to us
@ _____

Note to patient: You have been referred to an Oral Surgeon for specialized care and our office will make every effort to make your visit with us a comfortable experience. If you cannot make your appointment, please call us at least two business days in advance.

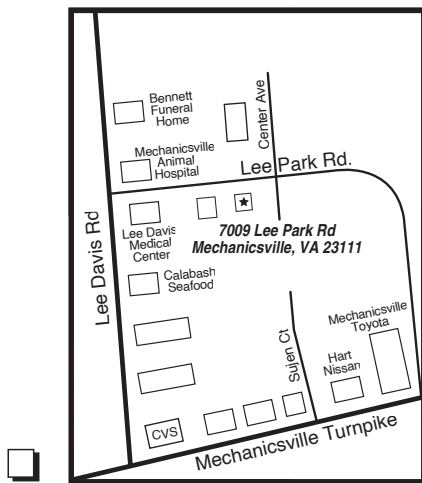
- Please bring any referral or treatment letters from your dentist.
- Filling out our patient forms online at www.commonwealthofs.com will expedite your visit.
- If you have medical and/or dental insurance, please bring the cards and appropriate information to your appointment.
- This initial appointment will consist of an assessment of your medical health history and a consultation explaining your diagnosis, treatment and anesthesia options. Any surgical procedures will be scheduled on a separate date and time.
- **If you are under the age of 18, a parent or legal guardian must accompany you to our office.**



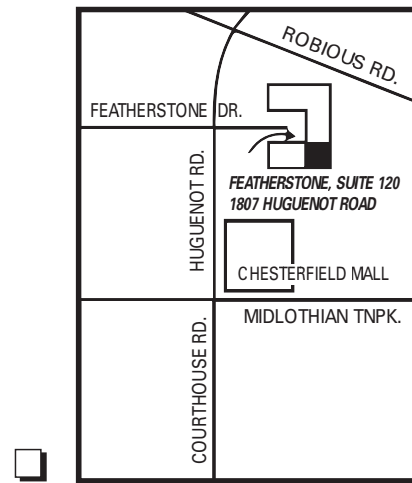
Brandermill Office
5942 Harbour Park Dr.
Midlothian, Virginia 23112



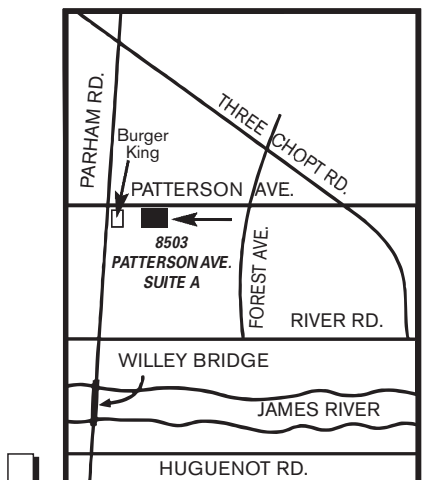
Chester
12220 Iron Bridge Rd., Suite B
Chester, Virginia 23831



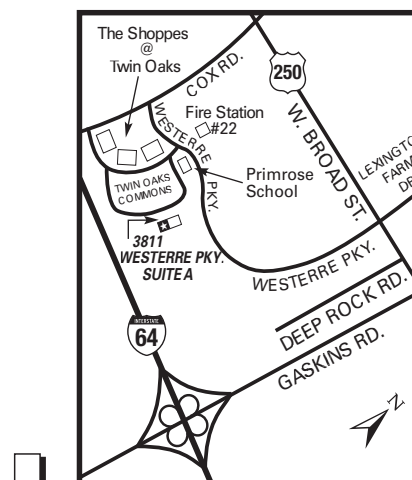
Mechanicsville
7009 Lee Park Road
Mechanicsville, VA 23111



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