

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. Greg Zoghby ☐ Dr. Jeff Cyr ☐ Dr. Drew Ferguson ☐ Dr. Ammar Sarraf ☐ Dr. Charlie Boxx
☐ Dr. Lauren Kaplan ☐ Dr. Nick Broccoli ☐ Dr. Sean Eccles ☐ Dr. Vickas Agarwal ☐ Dr. Pete Broccoli ☐ First Available

Office Locations:

- ☐ Brandermill 5942 Harbour Park Dr. Midlothian, VA 23112
☐ Chester 12220 Iron Bridge Rd. Suite B Chester, VA 23831
☐ Mechanicsville 7009 Lee Park Rd. Mechanicsville, VA 23111
☐ Midlothian/ Bon Air 1807 Huguenot Rd. Suite 120 Midlothian, VA 23113
☐ Patterson @Parham Road 8503 Patterson Ave., #A Henrico, VA 23229
☐ 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
RIGHT																	LEFT

Oral Surgery Procedure:

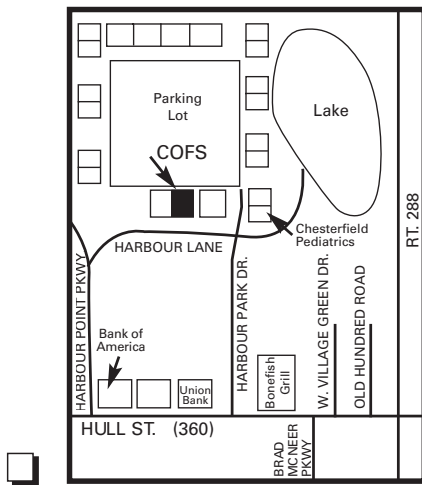
- ☐ Wisdom Teeth
☐ Extraction(s), teeth# _____
☐ With Socket Grafting ☐ With Immediate Implant
☐ Dental Implant(s), teeth # _____
Implant Preference: _____
☐ Intraoral Scan
☐ Full Arch Implant Evaluation
☐ Biopsy ☐ Apicoectomy ☐ Frenectomy
☐ Exposure ☐ Bracket, teeth # _____
☐ Orthognathic Evaluation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

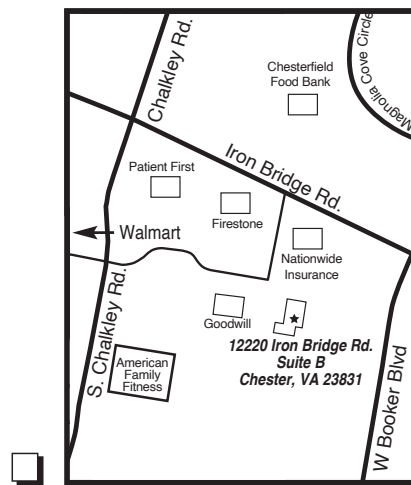
- ☐ Please provide the date taken of most recent x-rays.
*Panorex Date: _____
*PA Date: _____ Tooth #: _____
*Cone Beam CT Scan Date: _____
☐ X-ray emailed to referrals@commonwealthofs.com (OPTIONAL)
☐ Please send/forward copy of COFS x-ray to us @ _____

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.

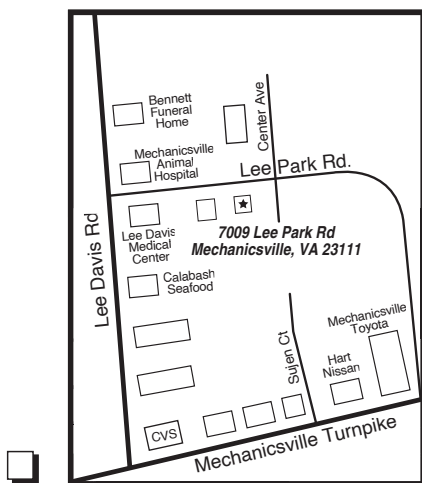
- Please bring any referral or treatment letters from your dentist.
- Please fill out your registration form online prior to your appointment at www.commonwealthofs.com
- If you have medical and/or dental insurance, please bring the cards and appropriate information to your appointment.
- This initial 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.**



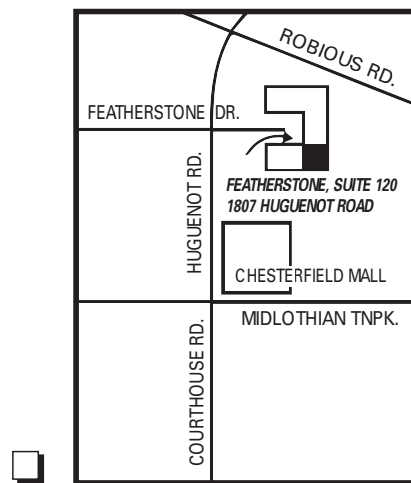
Brandermill Office
5942 Harbour Park Dr.
Midlothian, Virginia 23112



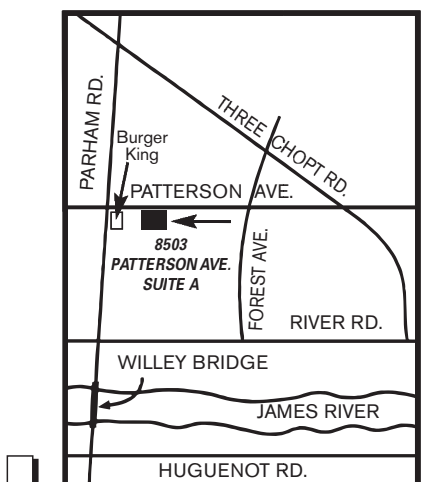
Chester
12220 Iron Bridge Rd., Suite B
Chester, Virginia 23831



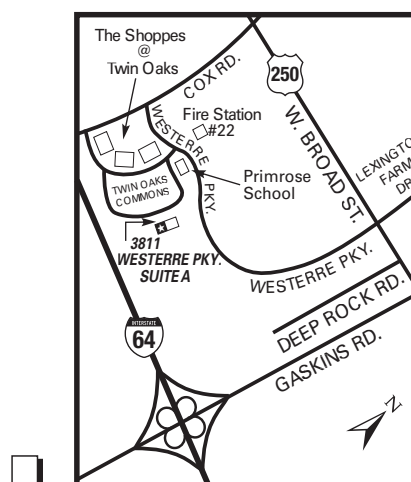
Mechanicsville
7009 Lee Park Road
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3811 Westerre Parkway, Suite A
Henrico, Virginia 23233