

STONY BROOK ORAL AND FACIAL SURGERY

207 Hallock Road, Suite 2, Stony Brook, New York 631-675-9601 Info@stonybrookoralsurgery.com

Patient Information:

Full Name _____ DOB _____
 Address _____ Contact Phone _____
 Email Address _____

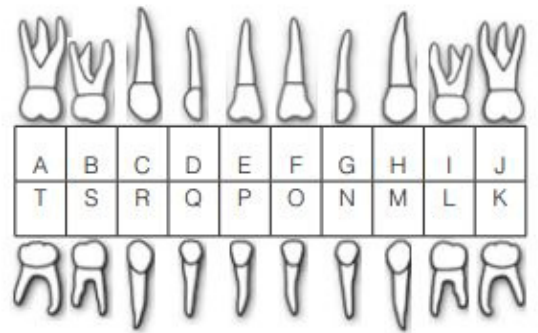
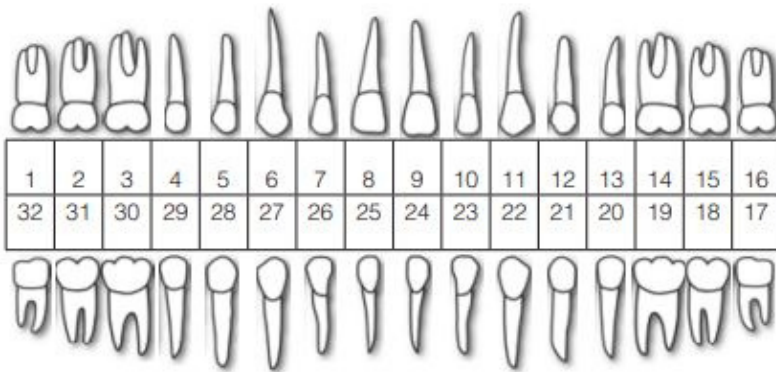
Requested Doctor Dr. M. Proothi Dr. M. Steinberg first Available

Referring Doctor's information:

Referred by _____ Contact Phone _____
 Practice Name _____

Reason for Referral / Procedure:

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Extraction (see below) <input type="checkbox"/> TMJ / TMD <input type="checkbox"/> Orthognathic Surgery <input type="checkbox"/> MSE/ MARPE <input type="checkbox"/> Biopsie | <ul style="list-style-type: none"> <input type="checkbox"/> Wisdom Teeth <input type="checkbox"/> Expose / Bond <input type="checkbox"/> Incision/ Drainage <input type="checkbox"/> Trauma <input type="checkbox"/> Frenectomy | <ul style="list-style-type: none"> <input type="checkbox"/> Apicoectomy <input type="checkbox"/> Zygoma Implants <input type="checkbox"/> Dental Implants/ Full Arch <input type="checkbox"/> Botox / Steroid Injection <input type="checkbox"/> Other _____ |
|---|--|---|



Consultation:

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Wisdom Teeth <input type="checkbox"/> TMJ <input type="checkbox"/> Orthognathic Surgery | <ul style="list-style-type: none"> <input type="checkbox"/> Oral / Facial Lesion <input type="checkbox"/> Zygoma Implants <input type="checkbox"/> Full Arch Restoration | <ul style="list-style-type: none"> <input type="checkbox"/> Bone Grafting <input type="checkbox"/> Cosmetic <input type="checkbox"/> Other _____ |
|--|---|---|

XRays / Pano / Images:

- Given to Patient
 Emailed
 Please take CBCT

NOTES