

Demographic Information

Patient Information

Patient Name: _____ Cell Phone Number: _____
 Date of Birth: _____ Date of X-Ray: _____

Referring Information

Referring Doctor Information

Referring Doctor: _____ Referring Doctor Phone Number: _____

Treatment Information

Diagnosis:

Diagnosis: _____

Permanent:

RIGHT **1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16** LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Deciduous:

RIGHT **A B C D E F G H I J** LEFT
T S R Q P O N M L K

3rd Molar Evaluation

Yes

No

Expose & Bond

Yes

No

Extractions

Yes

No

Full Arch Solution*

Yes

No

Implant Evaluation

Yes

No

Evaluate for Grafting

Yes

No

Pathology Evaluation

Yes

No

*A full arch solution requires a conference between doctors.

Conclusion

Additional Notes / Comments

Thank You For Your Referral

Please email xrays to:

info@niagaraoms.com

Fax - (716) 276-3552

All patients must have a pre-surgical consultation with Dr. Nigalye before scheduling surgery.

Please notify our office 72 hours in advance if you are unable to keep your appointment.

6490 Main Street, Suite 5, Williamsville, New York 14221

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