CRYSTAL COAST
ORAL & FACIAL SURGERY

RYAN T. HAGAN, DMD
WWW.CRYSTALCOASTOFS.COM

PATIENT REFERRAL

PATIENT'S NAME: _____ ***PATIENT'S DOB:*** _____

PATIENT'S PHONE #: _____ ***APPOINTMENT DATE & TIME:*** _____

Please call 252-288-5713 to schedule your patient's appointment. Send digital x-rays to crystalcoastofs@outlook.com.

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

DATE:_____ REFERRING DR._____

This patient is being referred for evaluation of the following:

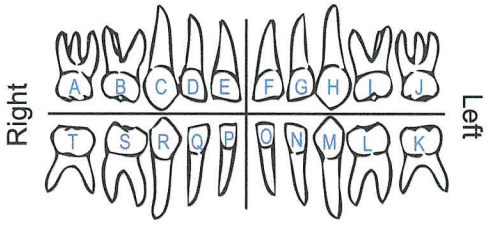
Extract/Expose:
- ☐ Extraction Tooth #_____
- ☐ Wisdom Teeth Removal
- ☐ Apicoectomy Tooth #_____
- ☐ Expose, Bond Tooth #_____

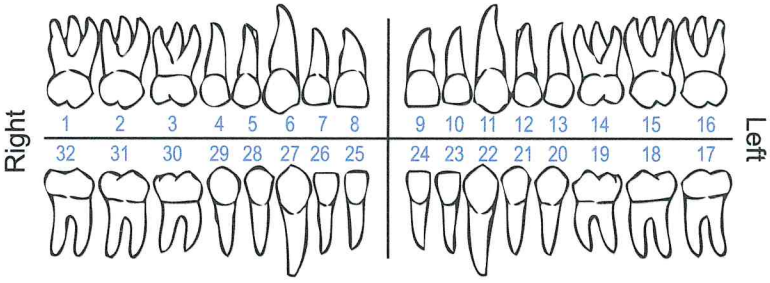
Dental Implants:
- ☐ Bone Graft Tooth #_____
- ☐ Site Preservation Tooth #_____
- ☐ Dental Implant(s) Tooth #_____

Pathology:
- ☐ Soft Tissue Lesion Evaluation
- ☐ Bony Lesion Evaluation

Other:_____

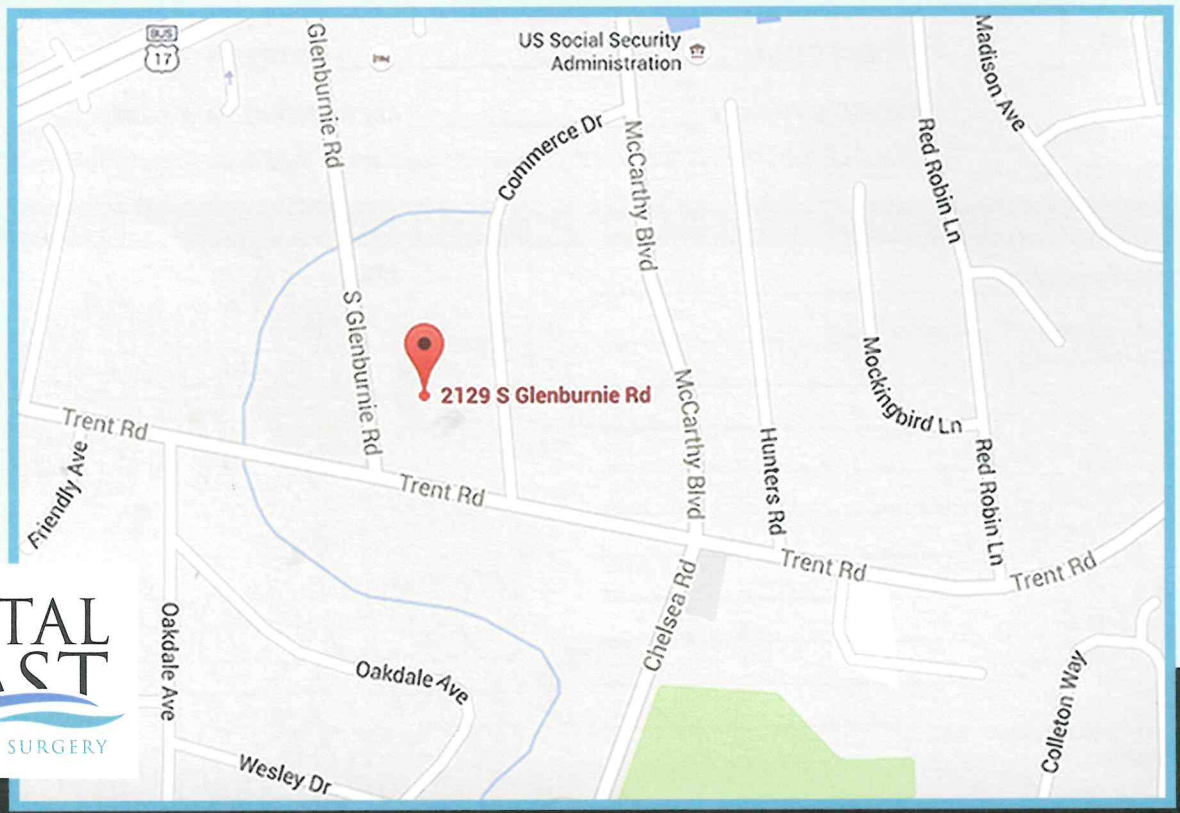
Comments:_____





☐ **Please call me before proceeding with treatment.** ☐ **I have sent radiographs for your evaluation.**

2129 S. Glenburnie Road #10 • New Bern, NC 28562 • Phone 252-288-5713 • Fax 252-288-5612



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