NORTHEAST
Oral and Maxillofacial Surgery

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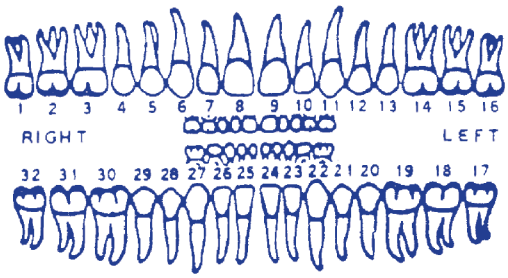
Referral Request:

- ☐ Extractions (mark **X** indicated teeth)
- ☐ Third Molars
- ☐ Expose and Bond
- ☐ Alveoloplasty
- ☐ Infection
- ☐ Pathology (location) _____



- ☐ Implants (circle indicated areas)
- ☐ Bone Graft / Socket Maintenance (area) _____
- ☐ General Anesthesia / IV Sedation / Nitrous Oxide
- ☐ Specific Concerns _____
- ☐ Significant Medical History _____
- ☐ **Patient will bring X-rays** **X-Rays sent** ___/___/___

Dr. _____ **Date** ___/___/___

Phone ( ) _____

Patient Information

DOB ___/___/___

Name _____

Phone ( ) _____

Appointment ___/___/___ _____ AM PM
Date Time

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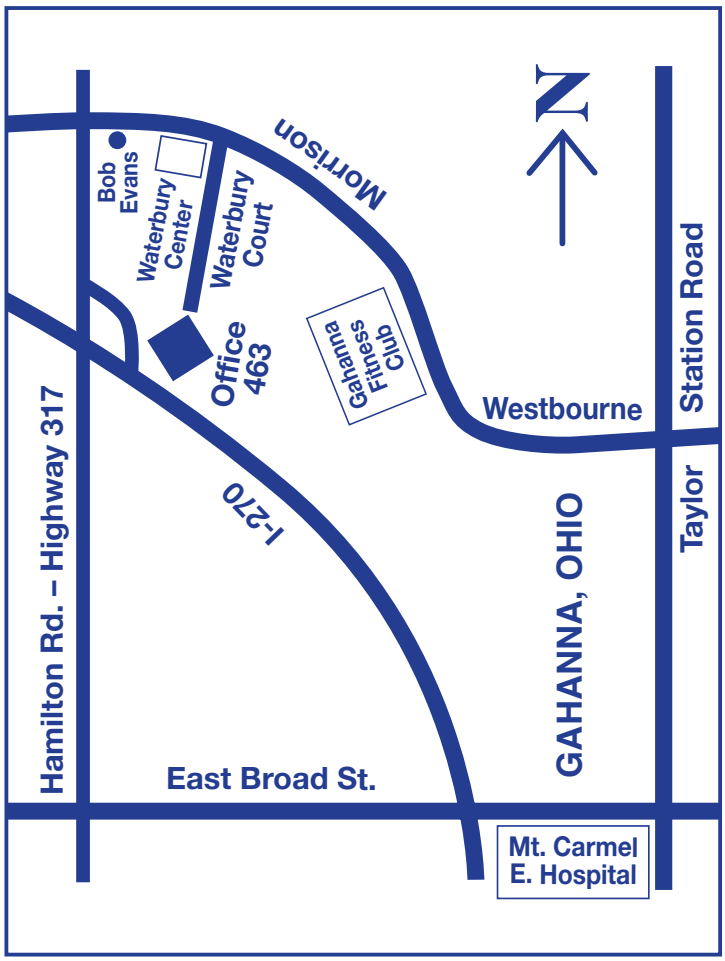
We are in NETWORK with:
- Careington
- DeCare
- Delta Dental PREMIER
- GEHA
- MetLife PDP PLUS
- Superior

***Connection Dental:**
The includes SOME of these plans:
- Aetna Dental
- United Healthcare
- United Medical Resources

***Connection Dental:**
This includes MOST of these plans:
- Ameritas
- Assurant
- Guardian
- Lincoln Financial
- Principal
- The Standard

*If any questions, please call our office at 614-471-6600.