PATIENT REFERRAL FORM

HAMPTON
ORAL & FACIAL SURGERY
(757) 838-3975

BASIC INFORMATION

Date _____

Patient name _____ Patient phone number _____

Referring Doctor _____ Teeth Number _____

REASON FOR REFERRAL

- ☐ Evaluation only
- ☐ Same day Extraction with Local
- ☐ Eval Biopsy
- ☐ Consult Implant
- ☐ Consult Wisdom Teeth
- ☐ Consult Botox

SYMPTOMS

- ☐ Pain
- ☐ Facial swelling
- ☐ Patient on antibiotics
- ☐ Other

REFERRAL FOR

- ☐ Dr. Trotter
- ☐ Dr.Ferguson
- ☐ Dr. Lee
- ☐ First Available

Notes for the Doctor _____

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* PLEASE HAVE THE PATIENT CALL THE OFFICE TO SCHEDULE AN APPOINTMENT.

3000 Coliseum Drive Suite 204 Hampton, VA 23666
www.https://www.hamptonoms.com/