



HOUSTON ORAL SURGERY ASSOCIATES

7500 San Felipe, Suite 300 • Houston, TX 77063 • p: 713.457.6337 • www.hosaoms.com

PATIENT INFORMATION:

Today's Date _____

First Name _____ Last Name _____ Date of Birth _____

Parent / Guardian Name _____

Contact Telephone _____ Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? ☐ Yes ☐ No • ☐ Patient will call for appointment ☐ Please call patient

Treatment _____

REFERRING DOCTOR'S INFORMATION:

Referred By _____ Telephone _____

E-Mail Address _____

REQUESTED SURGEON:

☐ Dr. Moya

☐ Dr. Maida

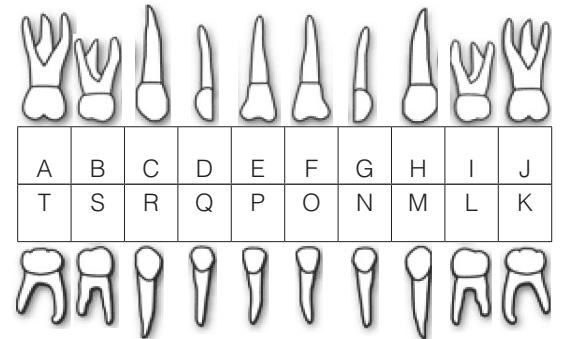
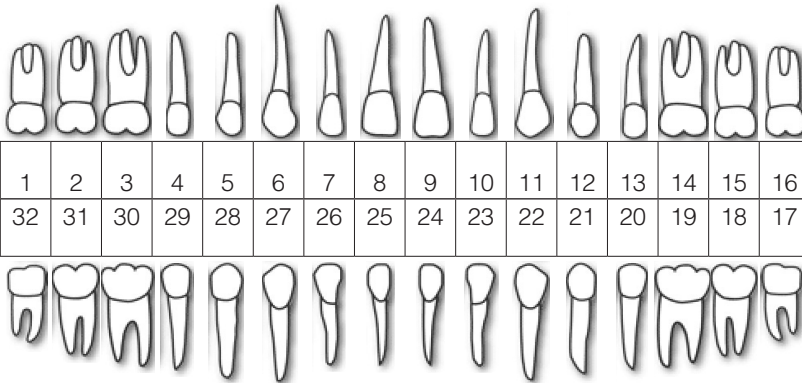
☐ First Available

PROCEDURES:

- ☐ Extraction (see below)
- ☐ Alveoplasty
- ☐ Biopsy
- ☐ Incision & Drainage
- ☐ Lesion Evaluation

- ☐ Exposure
- ☐ Hard Tissue
- ☐ Infection
- ☐ Expose & Bond
- ☐ Soft Tissue

- ☐ Frenectomy
- ☐ Apicoectomy
- ☐ Other



Please Verify Teeth For Extraction _____

CONSULTATIONS:

- ☐ TMJ
- ☐ Implants: ☐ Immediate ☐ Delayed
- ☐ Orthognathic Evaluation
- ☐ Pre-Prosthetic

- ☐ Cleft Lip & Palate
- ☐ Cosmetic
- ☐ Ridge Augmentation
- ☐ Oral / Facial Lesion

- ☐ Bone Grafting
- ☐ Other

RADIOGRAPHS OR CLINICAL PHOTOS:

- ☐ Being Mailed
- ☐ Given To Patient
- ☐ Please Take
- ☐ No X-Ray
- ☐ Attached With This Referral; if X-Rays are attached, what date were they taken _____

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.

AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

CASE NOTES: