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ORAL SURGERY CENTER
OF TEXOMA

Steven F. Kolb, DDS, MSD Todd J. Svane, DDS, MSD Calvin Vaughan, DDS, MD

Oral Surgery Evaluation / Treatment Request

Date: _____

Patient: _____ Phone: _____

Birthdate: _____

Referring Doctor: _____

Referred to: (circle one) First Available Doctor Dr. Kolb Dr. Svane Dr. Vaughan

Please evaluate / treat the following:

_____

_____

_____

_____

_____

☐ The patient will call to schedule an appointment.
☐ Please contact the patient to schedule an appointment.

RIGHT			A	B	C	D	E	F	G	H	I	J			LEFT
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

Radiographs?

☐ Being mailed ☐ Please take
☐ Sending with patient ☐ E-mailing

Immediate Denture/Partial?

Yes **No**

Who will be delivering it to our office?

☐ Referring office ☐ Lab ☐ Patient

Instructions For This Form:

White Copy:

Fax to: 903-893-6028 and keep for your records

Yellow Copy:

Send with patient

PARAMAX 903-436-1959

Instructions to Patients:

Please bring with you to your appointment:

- This referral slip and any x-rays
- A list of medications you are currently taking
- Medical and dental insurance information

Important Information:

- All patients under 18 years of age must be accompanied by a parent or guardian.
- Please alert our office if you have a medical condition that may be of concern prior to surgery (i.e. diabetes, high blood pressure, artificial heart valves and joints, rheumatic fever, aspirin or blood thinner use)