ASPEN
ORAL & FACIAL SURGERY

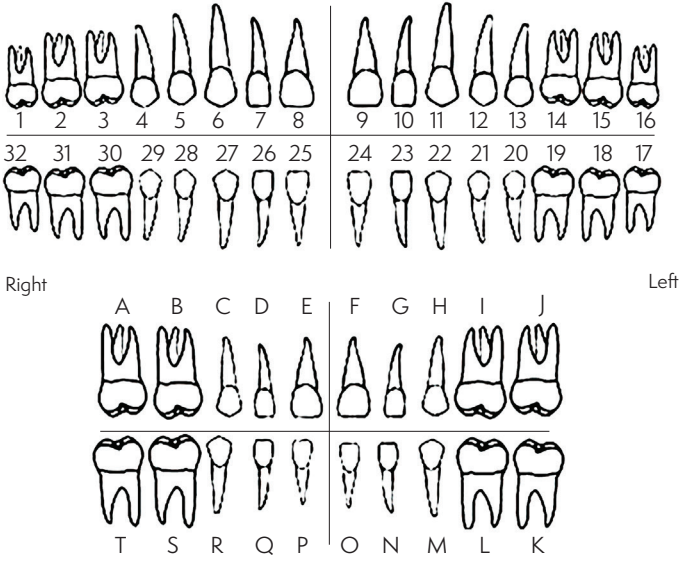
Eugene C. Kang, DMD, MD
www.aspenoralsurgery.com

PATIENT REFERRAL

Today's Date: _____ Referring Dr. _____

Patient's Name: _____ Patient's Phone: _____

Please call (303) 954-0049 to schedule your patient's appointment



Please bring current dental & medical insurance cards, this referral form and X-rays to your appointment.

General Anesthesia and Intravenous Sedation Patients ONLY:

1. Do not eat or drink for eight hours before scheduled appointment.
2. Bring an adult to drive and accompany you home.
3. Minors must be accompanied by parent or legal guardian.

Reason for Referral

- ☐ Extractions
- ☐ Wisdom Teeth
- ☐ Implants
- ☐ Bone Grafting
- ☐ Biopsy
- ☐ Exposure, Bond
- ☐ Frenectomy
- ☐ Alveoloplasty
- ☐ Infection
- ☐ Orthognathic
- ☐ TMJ
- ☐ Pre-Prosthetic
- ☐ Facial Trauma
- ☐ Cleft Lip, Palate Evaluation
- ☐ Other/Comments _____

☐ I have sent radiographs for your evaluation. **Date Taken**:

671 Mitchell Way Suite 100, Erie, CO 80516 Phone: (303) 954-0049 Fax: (720) 638-7577 info@aspenoralsurgery.com