MIAMI
ORAL & MAXILLOFACIAL SURGERY

JOSE I. MONTERO, D.D.S

Referral Form

Name: _____ Birth Date: _____

Referring Doctor: _____ Date:_____

Consult Indication (check all that apply):

- ☐ Extractions: _____
- ☐ Pathology: _____
- ☐ Bone Grafting: _____
- ☐ TMJ: _____
- ☐ Orthodontic: _____
- ☐ Implants: _____
- ☐ Other: _____

Please circle the area(s) of concern:

			A	B	C	D	E	F	G	H	I	J			
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			

Imaging Available (to send):

- ☐ **Periapical**
- ☐ **Panorex**
- ☐ **CBCT**
- ☐ **Photo**

Case Notes:

_____

_____

8940 N. Kendall Drive, Suite 604E, Miami, Fl, 33176 I P: (305)595-1905 I F: (305)595-2219
www.miamioms.com I Email: miamioms@miamioms.com