SANTA CLARA
ORAL SURGERY &
DENTAL IMPLANTS

Patient Name _____

Date of Birth _____ Patient Phone # _____

Referred by Dr. _____ Phone # _____

☐ **Please examine the circled areas below**

☐ **Please remove the teeth marked with an (x) below**

			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			

Remarks or Findings

Consultation for

☐ Implants ☐ Grafting / Augmentation ☐ Pathology / Biopsy

Recent Radiographs

☐ With Patient ☐ Sent to Office ☐ Please Take

Signature of Referring Dr. _____

Your Appointment with Dr. _____

Date _____ Time _____ AM/PM

Email: hello@sbayos.com
1150 Scott Blvd, Ste D1
Santa Clara, CA 95050
Phone: (408) 248 9597 | Fax: (408) 248 9590

PATIENT INSTRUCTIONS

The initial visit is typically for a consultation and evaluation. We tailor our care to your needs. If you prefer, you may be able to have your procedure done on the same day. Please inform the receptionist while you are making your appointment.

Please bring the following to your appointment:

1. This referral form
2. Names of your physician, any medications you are taking, and to which medications you are allergic
3. X-Rays (if your dentist has provided you with physical or digital copies)
4. Insurance card and completed insurance form

Minors under 18 years of age must be accompanied by a parent or guardian.

You have been referred for specialized care to an Oral and Maxillofacial Surgeon. We work with your dentist to ensure you receive proper and compassionate care. Please do not hesitate to contact us with any questions or concerns.

If you plan on undergoing IV sedation please do not eat or drink anything 8 hours prior to your appointment. An adult needs to accompany you and drive you home after the appointment.