SALTMAN
IMPLANTOLOGY & ORAL SURGERY

ZACH SALTMAN, DMD

Oral & Maxillofacial Surgeon

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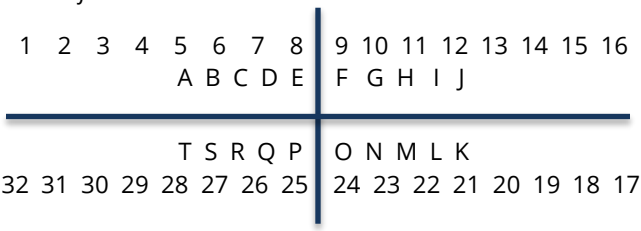
Date of Referral: ___/___/___
Patient Name: _____
Patient Phone: (_____) _____-_____

Referring Doctor: _____
Contact Phone: (_____) _____-_____
☐ Please contact me before treatment

Consultation for:

☐ Extraction(s)	☐ Socket preservation	☐ Exposure +/- bonding
☐ Titanium Implant	☐ Zirconia Implant	☐ Tissue Engineering
☐ Ridge Augmentation	☐ Sinus Augmentation	☐ Botox Injection
☐ 3D Cone Beam CT	☐ Alveoloplasty	☐ Biopsy/pathology
☐ TMJ & Myofascial Pain	☐ Other: _____	

Please circle teeth for evaluation:



Radiographs: ☐ e-mailed ☐ mailed ☐ with patient ☐ please return
Remarks:
_____
_____
_____