

Physician Referral Form



Please provide the following so we can schedule an appointment:

- PERTINENT MEDICAL RECORDS
 IMAGING
 INSURANCE AUTORIZATION (IF REQUIRED)

Patient information

Patient name: _____ M F

Street address: _____

City, state: _____ Date of birth: _____

Parent/guardian: _____

Please check preferred contact phone number:

- HOME: _____
 CELL: _____
 WORK: _____

Interpreter needed?
 YES
 NO
 Language: _____

Primary Care Provider (IF DIFFERENT FROM REFERRING): _____

This visit is (MARK ONE):

- Routine** WITHIN 30 DAYS
 Semi-urgent *WITHIN 2 WEEKS
 Urgent *LESS THAN 48 HOURS

*For urgent appointments, please call 404-778-4500

I am requesting:
 CONSULT ONLY
 ONGOING CARE
 REFERRAL REQUESTED BY PATIENT

With surgeon:
 Dr. Steven Roser
 Dr. Gary Bouloux
 Dr. Shelly Abramowicz
 Dr. Stephanie Drew

Please Evaluate for the following:

- Extraction of Teeth (please indicate below):
 Exposure and Bracketing (please indicate below):
 Implants (please indicate below):

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

- Orthognathic Surgery
 TMJ Pain/Dysfunction
 Pathology
 Radiographs
 Nerve Injury
 Sleep Apnea
 Facial Trauma
 Other: _____

Radiographs or Clinical Photos:
 E-Mailed
 Given to Patient
 Please Take
 No X-Ray

Referring provider information

Name: _____ Clinic: _____

City, state: _____ Phone no.: _____

Fax: _____ Email: _____

Office contact: _____

Please note:

Except for emergencies, the first appointment is for a consultation and evaluation only. Procedures to be performed will be discussed at the time of consultation, and a surgery date will then be scheduled.

Many insurance companies require a written referral from the primary care physician. Please make sure we receive the referral prior to scheduling, or the patient's insurance company may refuse to pay for services.

QUESTIONS ABOUT THIS REFERRAL? CALL US AT 404-778-4500.