



 117 South Calhoun Street
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MIDDLE GEORGIA
**ORAL & MAXILLOFACIAL
 SURGERY**

WILL SMALLEY, DMD
 BOARD CERTIFIED
 BY THE AMERICAN BOARD
 OF ORAL & MAXILLOFACIAL SURGERY

Patient Name _____ Date _____

Patient Phone _____ DOB _____

Patient Email _____

Referring Doctor _____ Phone _____ Email _____

Please Mark Teeth or Area to be Treated

	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					
R				T	S	R	Q	P	O	N	M	L	K					L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		

- Wisdom Teeth Removal
- Implant(s)
- Pathology
- Extraction(s)
- Bone Grafting
- Expose & Bond
- Other _____

Radiographs:

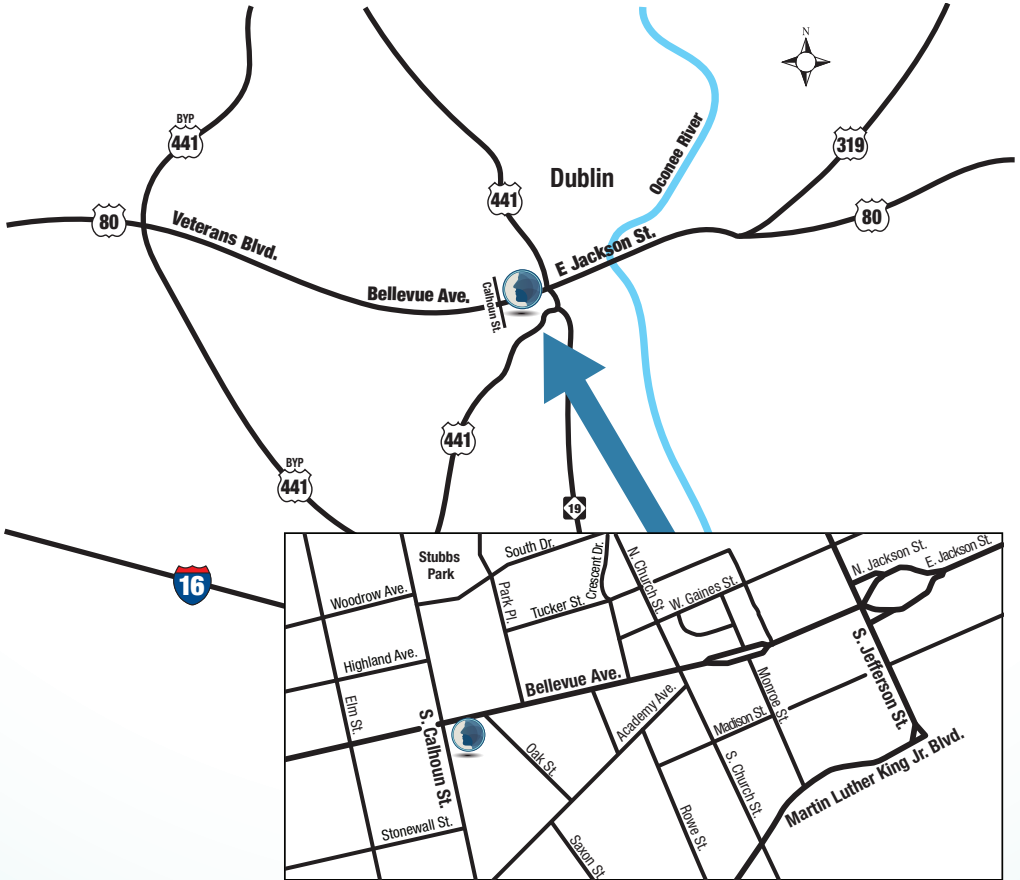
- Emailed
- Mailed
- Given to patient
- Please Take X-Rays

Date X-Rays were taken _____

Comments:

Signed _____

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Instructions for First Visit

Please complete your registration form before your appointment by visiting www.mgoms.com

Please bring the following items with you:

- This referral slip
- All X-rays
- A picture ID
- Medical and dental insurance cards/information
- Medications list
- An interpreter, if necessary

Please give 48 hours notice if you are unable to keep this appointment.