Dr Bobby Yang
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Facialmax
Oral & Maxillofacial Surgery

Patient name: ..... DOB: .....

Patient contact No.: .....

Referring doctor: ..... Date: .....

Contact No.: ..... Provider No.: .....

Email address: .....

Clinic address: .....

Reason for referral:

- □ Impacted wisdom teeth
- □ Other dental extractions (please specify)
- □ Exposure and bonding
- □ Orthognathic surgery
- □ Oral pathology
- □ Facial fractures
- □ TMJ
- □ Bone graft/ sinus lift
- □ Dental implants
- □ CBCT
- □ Other

Additional information: .....

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