

Oral Maxillofacial Surgery Services ROBERT S. JULIAN III, DDS, MD, INC. BRIAN M. WOO, DDS, MD, AND INC. GEORGE M. ZAKHARY DDS, MD. INC. NORTH MEDICAL PLAZA 215 N FRESNO STREET #490 FRESNO CA 93701 PHONE: (559) 459-4101



CONSULTATION REFERRAL FORM

		Date:		
Patient's Name:		DOB:		
Address:	City	y/State/Zip:		
Home Phone Number:		Cell/Other	:	
Appointment:	at	·		
Date	Ti	me	Primary Language	
Referring Provider (full name):	*Refer	ring Provider <u>NPI</u>	(REQUIRED):	
Address & Zip Code:				*
Referring Provider Fax #:		Office #:		
Office e-mail:				
Referred for Extraction of Teeth indicated below:				
1 2 3 4 5 6 7	8 9 10		13 14 15 16	
Right 32 31 30 29 28 27 26	25 24 23	22 21 2	0 19 18 17 Left	
Right A B C D T S R O	E F G P O N		Left	
Please Circle requ *Requesting Physician				
"Requesting Physician	: Dr. Julian / I Optional)		mary (Please Circle)	
HEALTH HISTORY		• /		
OTHER INSTRUCTIONS:				
1) Maxillofacial Fractures:				
2) Maxillofacial Cyst/Tumor:				
3) Head/Neck Cancer:				
4) Orthognathic Surgery (Currently in active Orthognathic Surgery (Currently Orthognathic Surgery (Currently Orthognathic Surgery (Currently Orthognathic Su				
5) Pre-prosthetic Surgery:				
6) Biopsy:				
7) Implants:				
8) BONE GRAFTING (Fax Most recent PARIO ch		the Year):		
9) Nasal / TMJ Surgery:				
10) Cleft and Craniofacial Team:				
44)				
Radiographs Available: Yes No		rt Available: 🛭 Yes		
EMAIL: ucsffresnoomfs@communitymedical.org []	•			informa
Please fax copy of				mioi ma

Dental Coverage: ☐ Yes ☐ No *** Medical Coverage: ☐ Yes ☐ No