

REFERRAL SLIP



1145 19TH ST. NW, SUITE 777, WASHINGTON, DC 20036 | PH: (202) 296-6600 FAX: (202) 296-2372

Dr. Virginia E. Lee, DMD

Today's Date: _____ Appt. Date: _____ Time: _____

Patient's Name: _____

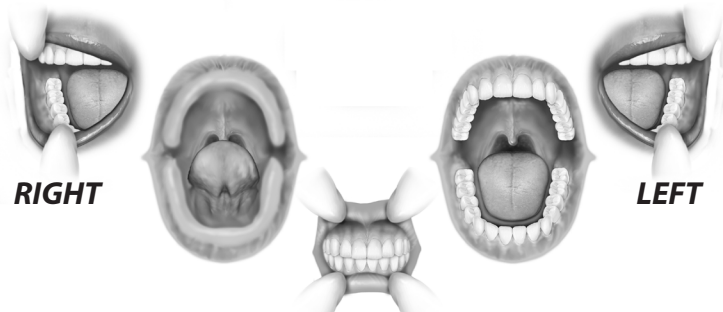
Referring Doctor's Name: _____

Referring Doctor's Phone: _____

PLEASE CIRCLE OR MARK (X) TEETH TO BE TREATED

<i>RIGHT</i>																<i>LEFT</i>									
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26

SOFT TISSUE CHART



Extraction Implant(s) Other

Please Select Your Implant System:

Zimmer 3i Nobel Strauman

Other (please specify): _____

Comments/Special Instructions: _____



CAPITAL
ORAL &
FACIAL
SURGERY CENTER

INSTRUCTIONS TO PATIENTS:

You have been referred for specialized care to an Oral and Maxillofacial Surgeon. Our office will make every effort to make your visit with us a comfortable experience.

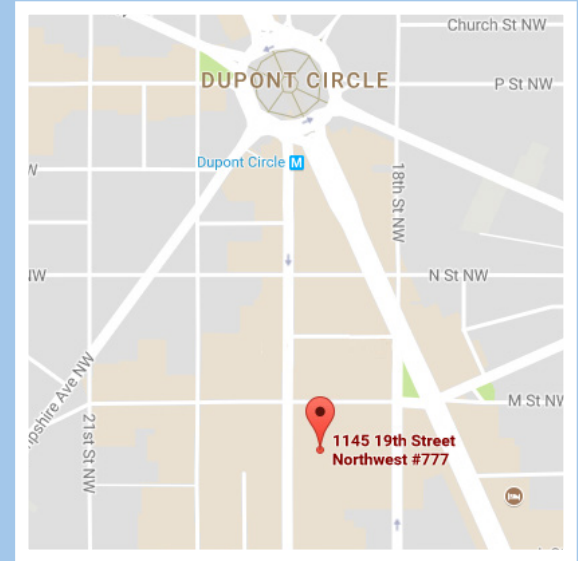
Please assist us by providing the following information at the time of your consultation.

- This referral slip and any X-rays, if applicable.
- A list of medications you are presently taking.
- If you have medical or dental insurance, fill out the necessary forms online at www.docvlee.com. This will save time and allow us to process any claims.

IMPORTANT: All patients under the age of 18 must be accompanied by a parent or guardian at the consultation visit.

- A pre-operative consultation and physical examination is mandatory for patients undergoing IV general anesthesia for surgery.
- Please alert the office if you have a medical condition that might be of concern prior to surgery (*ex: diabetes, high blood pressure, artificial heart valves and joints, rheumatic fever*).
- Our office is determined to address any concerns you may have about your appointment.

Please ask us so we may help you.



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