Dr. Dale R. Duncan

North Atlanta Oral and Maxillofacial Surgery

www.drdalerduncan.com

Email: drduncanoms@bellsouth.net

Alpharetta

2555 Westside Parkway
Suite 350
Alpharetta, Georgia 30004
Phone: 770-664-6533
Fax: 770-406-2063

Cumming

3275 Market Place Boulevard
Suite 175
Cumming, Georgia 30041
Phone: 770-664-6533
Fax: 770-406-2063

Referring Doctor:____

Referring Doctor Phone: ____

Referring Doctor Email: ____

Patient Name:____

Patient Date of Birth: ____

Patient Contact Name: ____

Patient Contact Phone: ____

Panoramic X-ray/FMX/CBCT

Date Last Taken: ____/____/____

____ **None Taken**

____ **Will Be Emailed**

____ **Given to Patient**

____ **Attached**

Referral Case Procedure(s):

- ☐ Third Molar Extraction
- ☐ Extraction
- ☐ Implant
- ☐ Biopsy
- ☐ Exposure
- ☐ Expose & Bracket
- ☐ Sinus Lift
- ☐ Ridge Augmentation
- ☐ Frenectomy
- ☐ Infection
- ☐ Alveoplasty
- ☐ Incision & Drainage
- ☐ TeethxPress Restoration
- ☐ Full Mouth
- ☐ Upper Arch
- ☐ Lower Arch
- ☐ Other: ____

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CIRCLE and/or "X" Teeth Indicated for REMOVAL **Implants at Site Number(s):** _____ ______ ______

Location/Additional Notes: ____

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