## Oral Surgeon Dr. Ming Yu, D.D.S SHARONVILLE Phone: 513-771-9190 Fax: 513-771-6208 Family Dental info@sharonvilleDental.com

Please indicate teeth to be extracted with an X.

11440 Lippelman Rd. Cincinnati, OH 45246

SharonvilleDental.com

Patients Full Name:  DOB:/	Date:/		Reason for Referral:	
Insurance:ID#: Alveoloplasty with full mouth extractions  Referring Doctor:	Patients Full Name:		☐ Wisdom Teeth Extractions	
Referring Doctor:  Phone#:  Root Canal (will not accept re-treats)  Restorative  Exostosis Removal  Tori Removal (with full mouth extractions only)  Requires IV Sedation  Other (specify below)  Specific concerns:  Significant Medical History (required):	DOB:/		☐ Extraction(s)	
Facility:Phone#: Root Canal (will not accept re-treats)  Restorative  Exostosis Removal  Tori Removal (with full mouth extractions only)  Requires IV Sedation  Other (specify below)  Specific concerns:  Significant Medical History (required):	Insurance:	ID#:	☐ Alveoloplasty with full mouth extractions	
Restorative  Exostosis Removal  Tori Removal (with full mouth extractions only)  Requires IV Sedation  Other (specify below)  Specific concerns:  Significant Medical History (required):	Referring Doctor:		☐ Scaling and Root Planning	
Exostosis Removal    Tori Removal (with full mouth extractions only)   Requires IV Sedation   Other (specify below)   Specific concerns:   Significant Medical History (required):	Facility:	_Phone#:	☐ Root Canal (will not accept re-treats)	
Tori Removal (with full mouth extractions only)  REGHT  32 31 30 29 28 27 26 25 24 23 22 21 29 19 18 17  Specific concerns:  Significant Medical History (required):	RIGHT 32 31 30 29 28 27 26 25 24 23 22 21 29 19 18 17		☐ Restorative	
RIGHT  REQUIRES IV Sedation  Other (specify below)  Specific concerns:  Significant Medical History (required):			☐ Exostosis Removal	
RIGHT    Other (specify below)   Specific concerns: Significant Medical History (required):   Significant History (required):			☐ Tori Removal (with full mouth extractions only)	
Specific concerns:  Significant Medical History (required):			☐ Requires IV Sedation	
Significant Medical History (required):			☐ Other (specify below)	
			Specific concerns:	
Signature of Referring Doctor:			Significant Medical History (required):	
Signature of Referring Doctor:				
			Signature of Referring Doctor:	