Oral Surgeon Dr. Ming Yu, D.D.S

SHARONVILLE Family Dental

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Date: ______/______/_________

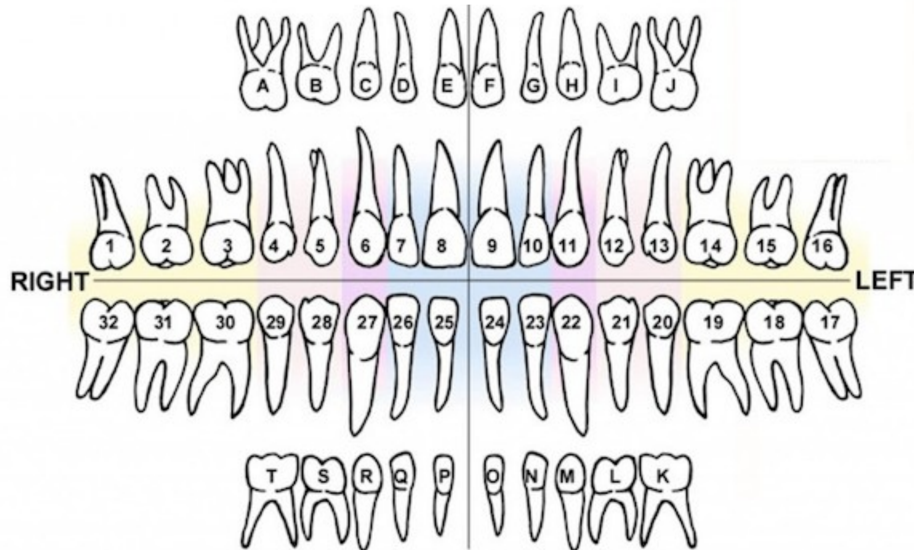
Patients Full Name: ________________________________

DOB: ______/______/_________

Insurance: ____________________ID#: _________________

Referring Doctor: ___________________________________

Facility: _________________Phone#: ___________________



Please indicate teeth to be extracted with an X.

Reason for Referral:

- ☐ Wisdom Teeth Extractions
- ☐ Extraction(s)
- ☐ Alveoloplasty with full mouth extractions
- ☐ Scaling and Root Planning
- ☐ 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):

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Signature of Referring Doctor:

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