THE COLLEGE OF Dental Medicine
The discipline of learning. The art of caring.

795 E. Second Street, Suite 8
Pomona, CA 91766-2007
Tel: (909) 706-3910 • Fax: (909) 469-8650

The Dental Center at Western University
Oral Surgery Referral Form

Please complete the form and fax it to: (909)469-8650. The first appointment cost for most patients is $157.00. Please ask your patient to contact The Dental Center at (909)706-3910 to schedule an appointment once this form is sent.

Today's Date:_____

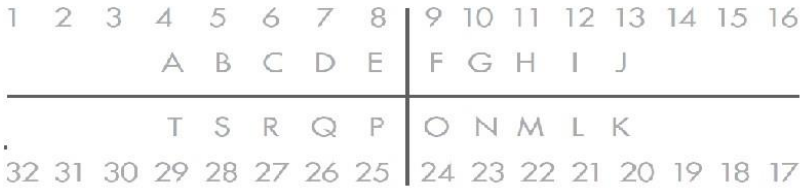
Patient Name:_____

Patient Primary Telephone :_____ **Other phone number:**_____

Patient Date of Birth:_____

Please indicate which teeth to be extracted: _____

(Place an "X" over the teeth you wish to extract after you print the form)



Other Procedures:

☐ Alveoplasty ☐ Biopsy ☐ Bone Graft ☐ Dental Implant

Comments:

_____

_____

_____

Name of Referring of Dentist: _____

Address: _____

Phone Number: _____

Signature of Referring Dentist:_____

revised 7.2017