



WILSON DENTAL

224 South Geddes St
Syracuse, NY 13204
315-423-9900 607-238-1276(Fax) contact@wilsondentalny.com

GENERAL REFERRAL

Introducing: _____ DOB: _____

Telephone: _____ Insurance: _____

REFERRAL WILL ONLY BE ACCEPTED WITH COPY OF PAN OR FMX EMAILED TO CONTACT@WILSONDENTALNY.COM

Date of last FMX/PANO: _____

Please circle the teeth or areas to be evaluated:

RIGHT

LEFT

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
<hr/>															
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PLEASE CHECK NEEDED BELOW

- RCT,P&C,CROWN Complete Dentures **Upper / Lower**
- Crown (We do not do crown lengthening) Extractions
- Occlusal Guard Partial Dentures **Upper / Lower**
- Comprehensive care: Please diagnose and treat all current dental needs and ask the patient to return to our office afterwards
- Transfer of Care: Please allow the patient to make Wilson Dental his/her permanent dental home

Additional Comments:

Referred by: _____

Referring office: _____

Signature: _____

Date: _____ Phone Number: _____