

Michael A. Casillas, D.D.S.
Michael B. Gissell, Jr., D.D.S., M.D.
Van R. Parker, III, D.D.S.
Jack W. Pool, D.D.S.
William E. Thornton, D.D.S., M.S.D.

All Certified by the American Board of Oral & Maxillofacial Surgery



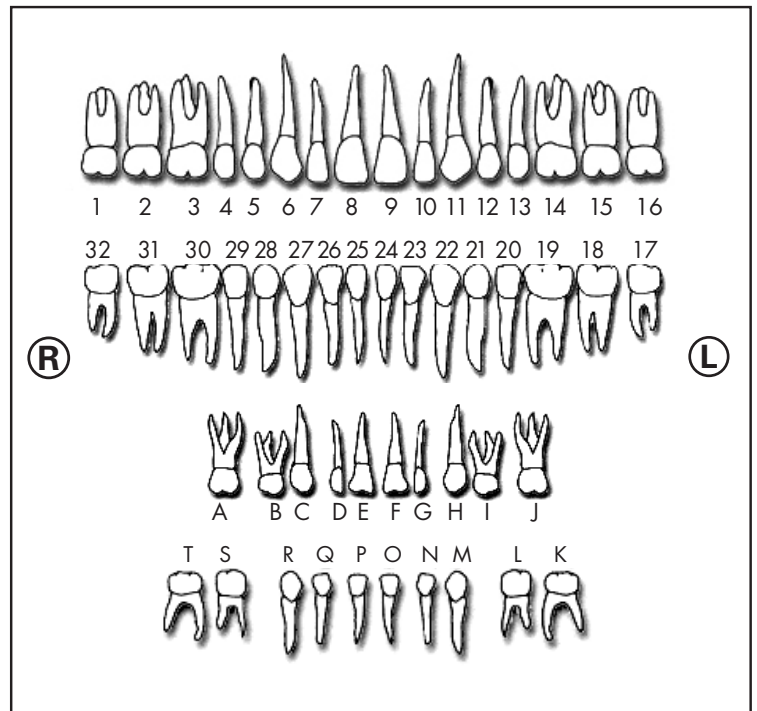
SAN ANTONIO SURGICAL ARTS

REFERRAL FORM

Date: _____ Please evaluate my patient: _____

for the following:

- Evaluation of Third Molars
- Extraction of Teeth
- Removal of Root Tip
- Frenectomy (Maxillary, Mandibular, Labial, Lingual)
- Alveoloplasty _____ Quadrant (s)
- Tori Removal _____ Quadrant (s)
- Expose & Bond
- Supernumerary
- Apicoectomy
- Abscess & Cellulitis
- Biopsy (location) _____
- Implant Evaluation
- Other _____



- FOR OFFICE USE
- X-ray enclosed
 - Please return x-ray
 - Please take new x-ray
 - Patient has appointment
 - Patient will call for appointment

Comments: _____

Referring Doctor: _____ Phone Number: _____

<p>6501 Blanco Rd. San Antonio, TX 78216 210-341-7264 Fax: 210-341-2022</p>	<p>1227 S.W. Military Dr. San Antonio, TX 78221 210-798-2666 Fax: 210-921-0811</p>	<p>3329 Wurzbach Rd. San Antonio, TX 78238 210-684-4324 Fax: 210-680-2104</p>	<p>1572 E. Common St. New Braunfels, TX 78130 830-606-3084 Fax: 830-624-1029</p>	<p>403 N. Milam Seguin, TX 78155 830-379-3977 Fax: 830-303-0700</p>	<p>602 S. Main Boerne, TX 78006 800-965-7421 Fax: 210-680-2104</p>
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