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Bakersfield Oral Surgery & Implant Center
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Oral & Maxillofacial Surgery

BRING THIS REFERRAL, INSURANCE CARD, AND A VALID DMV D.L. OR DMV I.D.

Introducing (Patient's Name): _____

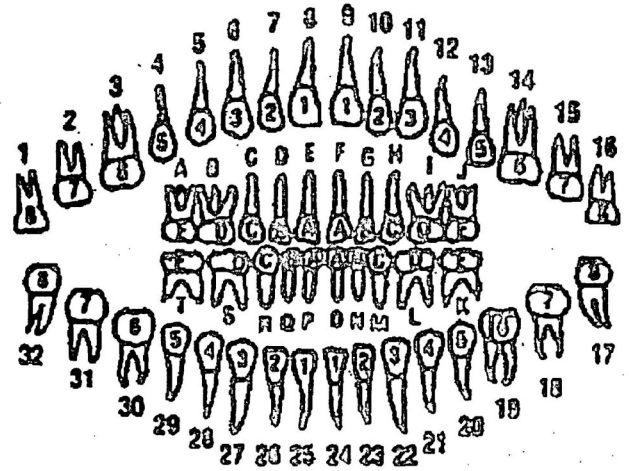
Appointment Date: _____ Time: _____ Day: _____

NOTE: This time is specifically reserved for you. Please notify out office at least 24 hours in advance if you must cancel this appointment. First appointment is ALWAYS an evaluation.

Referred For: Surgery Consultation Other

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Pre Prosthetic Surgery |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Implant |
| <input type="checkbox"/> Trauma | |

Please circle teeth to be removed. Indicate surgery to be performed or area to be examined



Remarks: _____

Referred by Dr. _____ Date: _____