Michael T. Shannon, D.M.D.
Michael J. Hunter, D.M.D.
Telephone: (978) 682-5255
Facsimile: (978) 682-0656
E: info@northeastoralsurgery.com

PATIENT REFERRAL

First Name		Last Name	
Birth Date		Phone	

Treatment Requested:

- ❑ Dental Implant(s):
  - ❑ *3i*
  - ❑ *Straumann*
  - ❑ *Nobel*
- ❑ Extraction(s)
- ❑ Evaluate Lesion
- ❑ Surgical Exposure
- ❑ Other _____

Please Indicate Tooth to be Treated

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Radiographs: Type of x-ray being sent:_____

☐ Given to patient ☐ Mailed ☐ Emailed to info@northeastoralsurgery.com ☐ Please take

Remarks:

Referring Provider Signature		Date	
Printed Name			

North Andover Medical Park (across from Bertucci's)
203 Turnpike Street, Suite G-2
North Andover, MA 01845

Appointment Date:_____ **Time:**_____

We require registration forms to be filled out prior to your visit. Please scan this QR code to be directed to our website

www.northeastoralsurgery.com