Fallon
ORAL SURGERY OF SYRACUSE
Timothy Fallon, D.D.S., M.D. P. Casey Fallon D.D.S.
Paul T. Fallon D.D.S. Kipp Slocum D.D.S.

PATIENT REFERRAL FORM – IMPLANT

Introducing: _____

Appointment: _____

Referred by: _____

X-Ray Sent: ☐ With Patient ☐ By Mail

Anesthesia:

- ☐ Local Anesthesia
- ☐ IV Sedation
- ☐ General Anesthesia
- ☐ N_2O Sedation

Planned Restoration:

_____

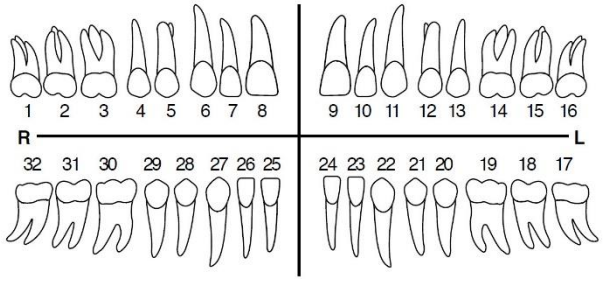
_____

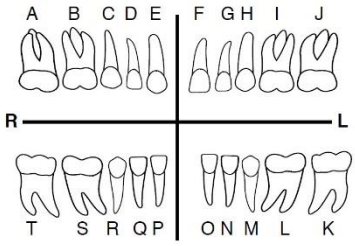
_____

_____

_____

Site:





Remarks:

Directions:

By Email:
FallonOralSurgery@aspidamail.com

By Fax:
1.315.453.0150

By Mail:
Fallon Oral Surgery of Syracuse
West Taft Medical Park
4820 West Taft Road Suite 109
Liverpool, NY 13088
1.315.451.6988