TIMOTHY FALLON D.D.S., M.D. P. CASEY FALLON D.D.S.
PAUL T. FALLON D.D.S.

PATIENT REFERAL FORM – ORTHOGNATHIC & CRANIOFACIAL

Introducing: ____

Appointment: ____

Referred by: ____

X-Ray Sent: ☐ With Patient ☐ By Mail

Remarks:

Directions:

By Email:
frontdesk@fallonoralsurgery.com

By Fax:
1.315.453.0150

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