



Timothy Fallon, D.D.S., M.D.

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Paul T. Fallon D.D.S.

Kipp Slocum D.D.S.

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## PATIENT REFERRAL FORM – ORTHOGNATHIC & CRANIOFACIAL

Introducing: \_\_\_\_\_

Appointment: \_\_\_\_\_

Referred by: \_\_\_\_\_

X-Ray Sent:       With Patient       By Mail

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**Remarks:**

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**Directions:**

**By Email:**

FallonOralSurgery@aspidamail.com

**By Fax:**

1.315.453.0150

**By Mail:**

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