FALLON ORAL SURGERY OF SYRACUSE
TIMOTHY FALLON D.D.S., M.D. P. CASEY FALLON D.D.S.
PAUL T. FALLON D.D.S.

PATIENT REFERAL FORM - IMPLANT

Introducing: _____

Appointment: _____

Referred by: _____

X-Ray Sent: ☐ With Patient ☐ By Mail

Anesthesia:

☐ Local Anesthesia
☐ IV Sedation
☐ General Anesthesia

Planned Restoration:

_____

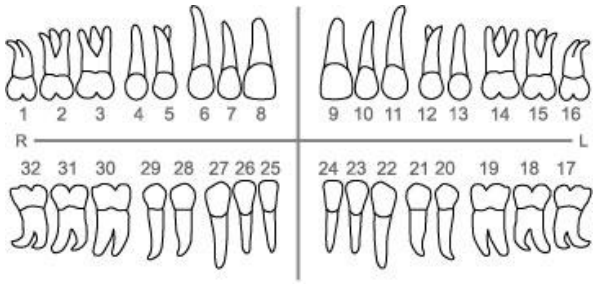
_____

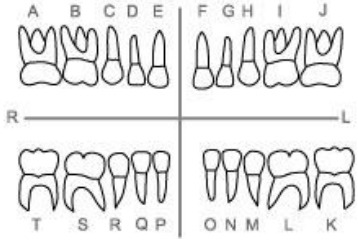
_____

_____

_____

Site:





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