WISDOM TEETH CLINICS

www.wisdomteethclinics.com
info@wisdomtethclinics.com
1300 988 881 (Patient enquiries)

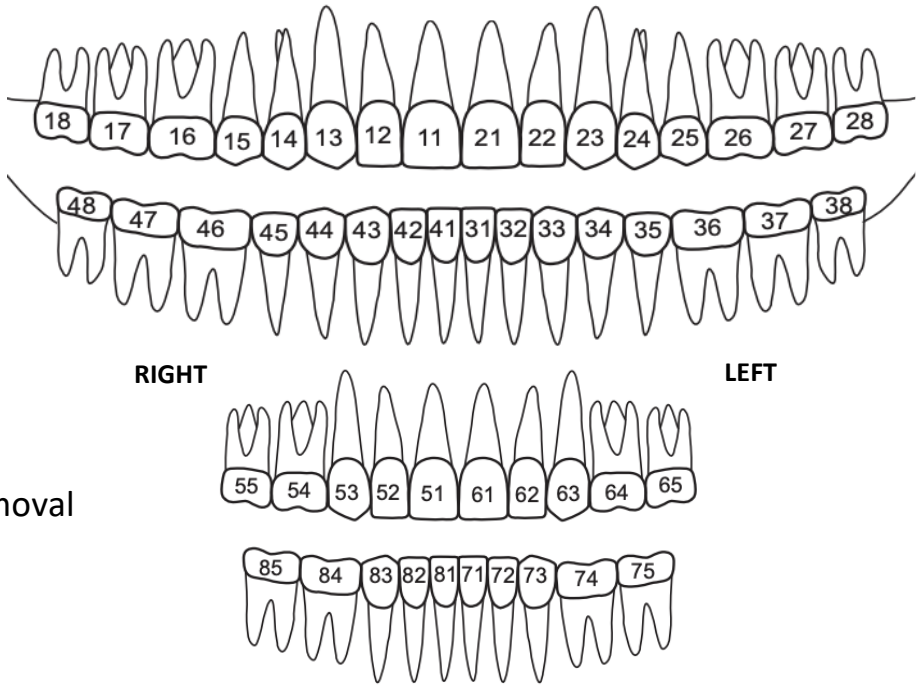
Patient Name:

DOB: **Phone:**

E-mail:

Reason for referral:

- ☐ Removal of teeth
- ☐ Expose & bond
- ☐ Alveoloplasty
- ☐ Frenectomy
- ☐ Operculectomy
- ☐ Biopsy
- ☐ Mucocele or cyst removal



History or comments:

Imaging performed: OPG CT CBCT PA
(please email digital copies to info@wisdomteethclinics.com)

Referrer name: **Provider Number:**

Practice address:

Signature: **Date:**

Call 1300 988 881 to schedule an appointment
or email info@wisdomteethclinics.com