

Embarcadero Dentistry

Darin T. Johnston, D.D.S.

Oral and Maxillofacial Surgery

Two Embarcadero Center, Promenade Level

San Francisco, CA 94111

Tel. (415) 398-4400

Fax. (415) 398-1748

Patient _____ Date _____

Patient's Phone Number _____

Referred by _____

Restoring provider (if different) _____

Stay plate (if applicable) will be provided by _____

Reason for Referral

Extract # _____

Implant # _____

Pathology _____

Expose/bond # _____

Other _____

Tooth Replacement Plan

****Treatment may be delayed/compromised if patient is referred without a tooth replacement plan**

Implant # _____

Bridge # _____

Complete Denture/Partial Denture

☐ Patient declines tooth/teeth replacement

Radiographs available:

PA / Panorex / CBCT

Patient interested in:

IV Sedation - YES / NO

Same day treatment - YES / NO

**Email photo of this referral form,
radiographs, and clinical photos to:**

JohnstonOMFS@gmail.com

Additional Information _____