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 __________________

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Reason for Referral

Extract # ___________________
Implant #___________________
Pathology __________________
Expose/bond # ______________
Other_________________________________
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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 ____
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