REFERRAL REQUEST

Salman A. Malik, D.M.D., M.D.
Board Certified in Oral & Maxillofacial Surgery

Patient: _____ DOB: _____ Phone: _____

Patient Address: _____

Date: _____ Referring Doctor: _____

Please circle the teeth to be treated:

				A	B	C	D	E	F	G	H	I	J			
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16 **L**
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			

X-Rays:

- ❒ Have been mailed/emailed
- ❒ Patient will bring to appointment
- ❒ Patient will need an X-ray

Please verify in writing the tooth/teeth that you would like treated, and list any special instructions that you may have:

Londonderry Professional Park
80 Nashua Road
Londonderry, NH 03053
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603-425-6165 Fax

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