



Northern Star

Oral and Maxillofacial Surgery PLLC

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www.northernstaroms.com

Referral for Oral Surgery

Presenting _____ Date of birth _____

Date _____ Patient phone number _____

Radiographs: With patient Mailed Emailed

Should we contact patient to schedule? Yes No

Reason for Referral

- | | | |
|--|---|---|
| <input type="checkbox"/> Extraction/Surgical Removal | <input type="checkbox"/> Pathology | <input type="checkbox"/> Implant Consult |
| <input type="checkbox"/> Uncovery/Exposure | <input type="checkbox"/> Trauma/Facial Fracture | <input type="checkbox"/> Orthognathic Consult |
| <input type="checkbox"/> Apical Surgery | <input type="checkbox"/> Cleft palate | <input type="checkbox"/> TMJ Consult |

Comments _____

			A	B	C	D	E		F	G	H	I	J				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	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				

Referring doctor _____

Office phone _____ May we communicate via email? Yes No

If yes, email address _____

For all Patients

- PLEASE bring this referral with you.
- If you take prescription medications, check with your surgeon for day of surgery instructions.
- If you do not have a consultation prior to your surgery and plan on having treatment on your first visit to the office, please verify your insurance prior to your appointment. Bring all insurance ID cards to your appointment.

For Patients Having Sedation/General Anesthesia (Asleep for your surgery)

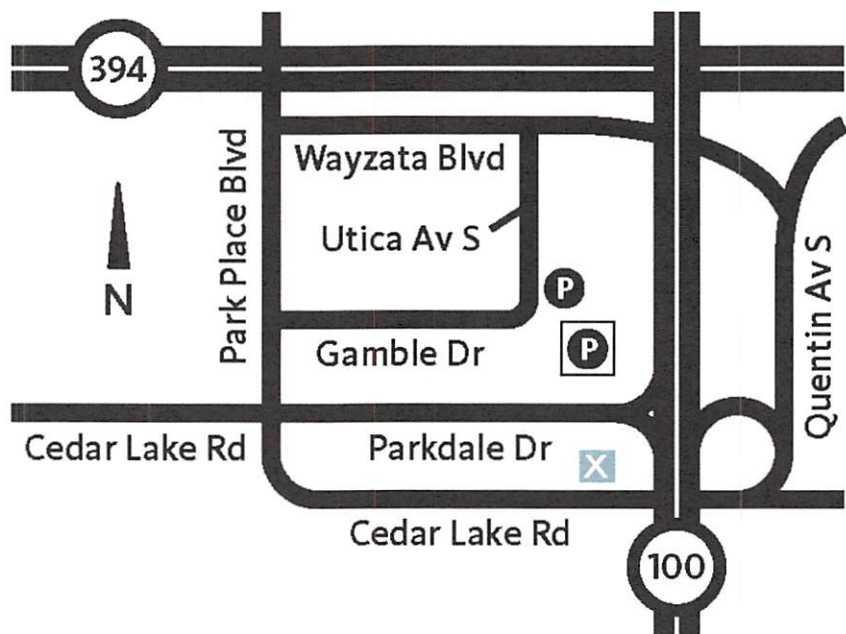
- Do not eat or drink anything, including water, within 6 hours of your appointment



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St. Louis Park Location



- Our office is in the red brick building labeled "West End Plaza".
- Enter on the north side of the building.
- Park in the north side lot or in the ramp on the west side of the building.

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