



SANTA FE ORAL SURGEONS

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Fellow, American Association
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Date _____

Patient Name _____

Telephone # _____

- X-Rays Enclosed
- X-Ray Required
- X-Ray sent via email to
wheatonreid@gmail.com
(.jpg format only)

Referring to:

- Dr. Jeffery Wheaton
- Dr. Douglas Reid
- Dr. Wheaton or Dr. Reid

Reason for referral: _____

Referring Doctor: _____

Signature

**Patients can submit forms online at:
www.santafeoralsurgeons.com**