



## **MOUNTAIN VIEW ORAL SURGERY**

105 South Drive, Suite #130, Mountain View, CA, 94040

Phone: (650) 938-7703 Fax: (650) 938-7705 E-mail: [mtnviewoms@gmail.com](mailto:mtnviewoms@gmail.com)

Visit us at [www.mtnvieworalsurgery.com](http://www.mtnvieworalsurgery.com)

**Sumit Nijhawan DDS, MD, FACS**

Diplomate, American Board of Oral and Maxillofacial Surgery

**Arjun Kulandaivelu DDS**

Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Office Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient's Email: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Insured's/Patient's SSN (optional): \_\_\_\_\_

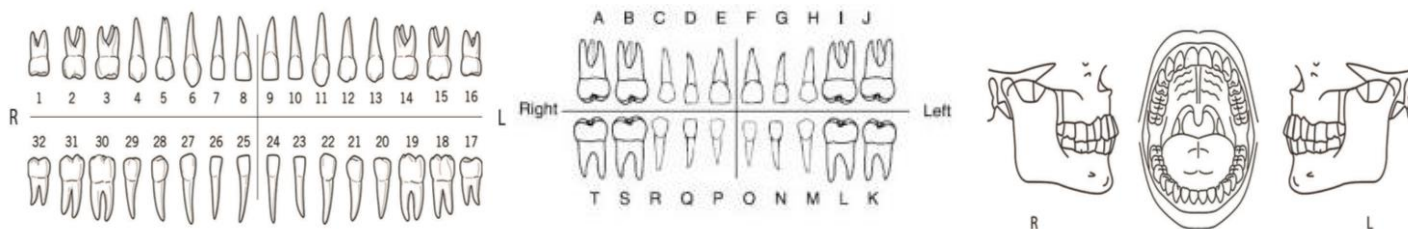
Primary Insurance and Insurance ID Number: \_\_\_\_\_

Secondary Insurance and Insurance ID Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

- |   |  |  |                                    |                                      |                                       |   |
|---|--|--|------------------------------------|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Implant(s)     | <input type="checkbox"/> Alveoloplasty | <input type="checkbox"/> Expose/Bond   | <input type="checkbox"/> TMJ Eval  | <input type="checkbox"/> Frenectomy  | <input type="checkbox"/> Botox/Filler | Preferred Implant System:<br><input type="checkbox"/> Nobel Active<br><input type="checkbox"/> Zimvue<br><input type="checkbox"/> Straumann |
| <input type="checkbox"/> Extractions(s) | <input type="checkbox"/> Biopsy        | <input type="checkbox"/> Orthognathics | <input type="checkbox"/> Infection | <input type="checkbox"/> Soft tissue | <input type="checkbox"/> Trauma       |   |
| <input type="checkbox"/> Other          |  |  |                                    |                                      |                                       |   |
|   |  |  |                                    |                                      |                                       |   |

Please circle teeth/areas, and provide additional information:



Additional Comments/Reason For Referral: \_\_\_\_\_

### Patient instructions:

- Please bring this referral slip to your appointment
- Bring your list of medications and dosages
- If you are more than 15 minutes late, we may need to reschedule your appointment
- You may visit us online at [www.mtnvieworalsurgery.com](http://www.mtnvieworalsurgery.com) and fill out registration and health history forms to expedite your appointment
- Minors must be accompanied by an adult or legal guardian
- Bring your government issued ID and insurance ID card
- If you have X-rays from a prior consultation or from your dentist, please bring them to your appointment

### Confidentiality Statement

Confidentiality Note: The documents accompanying this transmission may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivery to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments.