Level 2, 1 Hutt Street
Adelaide SA 5000
P: 08 8232 3525
F: 08 8232 3527
E: reception@oromax.com.au

oro max
clinic

REFERRED BY DR: ________________ **PROVIDER NO:** ________________

ADDRESS: ________________

TELEPHONE: ________________ **SIGNATURE:** ________________

This form must be completed by a registered dental and/or medical practitioner to be eligible for Medicare rebate for consultation.

REFERRAL TO:

- ❑ Dr Bruce Robinson
- ❑ Dr Miles Doddridge
- ❑ Dr Paul Sambrook
- ❑ Dr Tom Jaunay
- ❑ Dr Justin Collum
- ❑ Next available surgeon

DATE: ________________

PATIENT NAME: ________________

DOB: ________________

PATIENT ADDRESS: ________________

PATIENT EMAIL: ________________

PATIENT PHONE: ________________

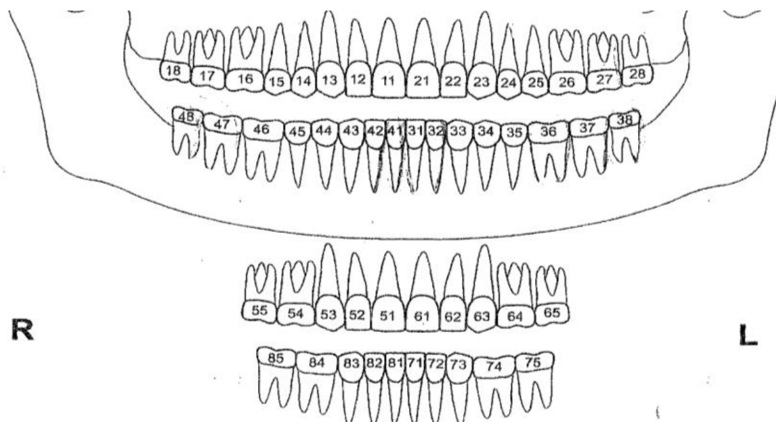
CONSULTATION FOR: ________________

____

____

SURGICAL REMOVAL OF: ________________

Please handwrite teeth numbers and also circle below.



- ❑ **Exposure of indicated teeth**
- ❑ **Oral pathology**
- ❑ **Corrective jaw surgery**
- ❑ **Facial Fractures**
- ❑ **Preprosthetic oral surgery including Dental Implants (System preferred)**

Other reasons for referral or comments:

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RADIOGRAPHS

- ❑ **Radiographs post to EAOMC**
- ❑ **No Radiographs**
- ❑ **Radiographs given to patient**
- ❑ **Organised Radiograph for patient to bring4**

YOUR CONSULTATION APPOINTMENT IS

AT: ________________

ON: ________________

This appointment has been reserved specifically for you.
Please contact 8232 3525
if you need to change or cancel this appointment.

Please assist us by providing the following information at the time of your initial consultation:

- Your referral and x-rays if applicable
- A list of medications you are presently taking
- Your GPs name, address and telephone number
- If you have medical or dental health insurance, please bring the necessary information
- Your Medicare card

Incorporating the ***ADELAIDE DENTAL IMPLANT SURGICAL CENTRE***