



1

6000 Fairway Drive
Suite #10
Rocklin, California 95677

Jared Antrobus, D.D.S.
Board Certified
Oral & Maxillofacial Surgeon

(916) 632-5809
Fax (916) 632-5814
www.rocklinoralsurgery.com
frontdesk@rocklinoralsurgery.com

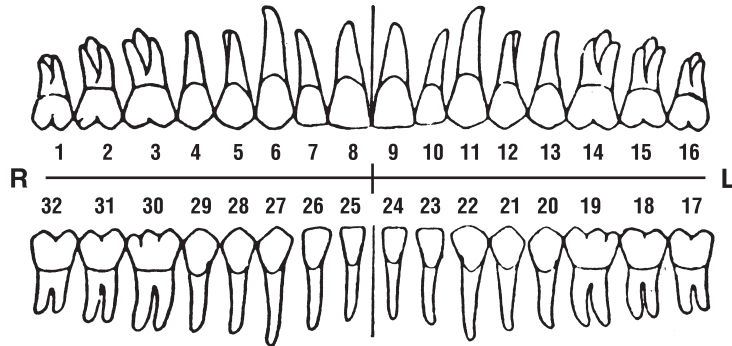
Introducing _____

Referring Dr. _____ Date _____

Patient Phone _____

X-rays: ☐ Mailed ☐ Copies given to patient ☐ Please take new ☐ Emailed to Dr. Antrobus

Please mark [X] for extraction or circle teeth or area to be treated.



R A B C D E F G H I J L
T S R Q P O N M L K

- | | |
|--|--|
| ☐ Extraction | ☐ Infection |
| ☐ Implant | ☐ Cyst/Tumor |
| ☐ Bone Grafting | ☐ Biopsy |
| ☐ Expose & Bond | ☐ Pre-prosthetic |
| ☐ Apicoectomy | ☐ Orthognathic Evaluation |
| ☐ Alveoplasty | ☐ Oral/Facial Trauma |

*In-Office Cone Beam CT's are available

Remarks _____



1

6000 Fairway Drive
Suite #10
Rocklin, California 95677

Jared Antrobus, D.D.S.
Board Certified
Oral & Maxillofacial Surgeon

(916) 632-5809
Fax (916) 632-5814
www.rocklinoralsurgery.com
frontdesk@rocklinoralsurgery.com

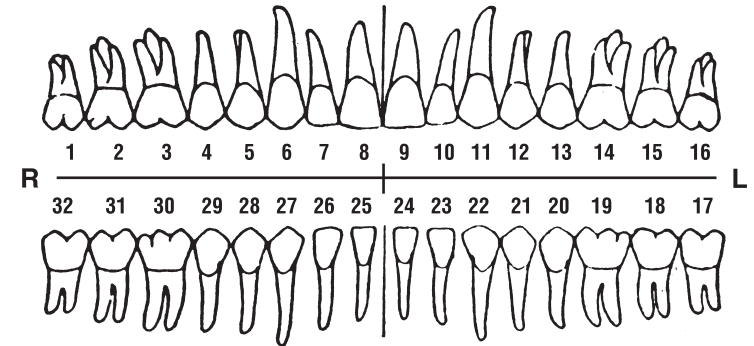
Introducing _____

Referring Dr. _____ Date _____

Patient Phone _____

X-rays: ☐ Mailed ☐ Copies given to patient ☐ Please take new ☐ Emailed to Dr. Antrobus

Please mark [X] for extraction or circle teeth or area to be treated.



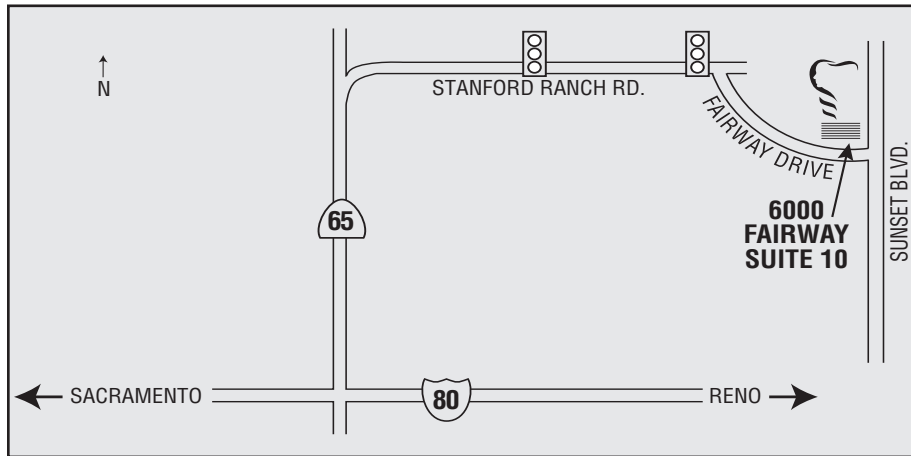
R A B C D E F G H I J L
T S R Q P O N M L K

- | | |
|--|--|
| ☐ Extraction | ☐ Infection |
| ☐ Implant | ☐ Cyst/Tumor |
| ☐ Bone Grafting | ☐ Biopsy |
| ☐ Expose & Bond | ☐ Pre-prosthetic |
| ☐ Apicoectomy | ☐ Orthognathic Evaluation |
| ☐ Alveoplasty | ☐ Oral/Facial Trauma |

*In-Office Cone Beam CT's are available

Remarks _____

OFFICE MAP



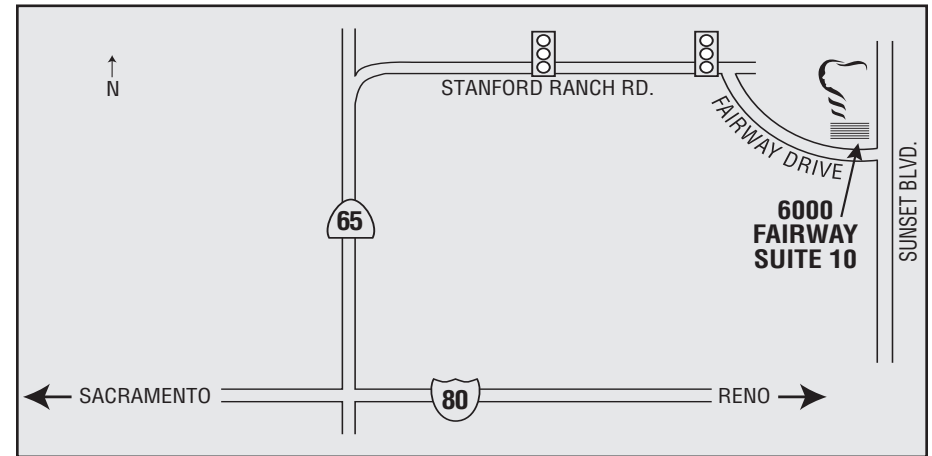
PATIENT INSTRUCTIONS

You have been referred for specialized care with an Oral and Maxillofacial Surgeon. We seek to provide the highest quality oral surgery services for your individual needs. Please assist us by providing the following information at the time of your consultation.

- The day of your appointment please bring:
 1. This referral slip.
 2. Current x-rays (if available).
 3. Insurance cards (if you have them). You may also fill out the Patient Registration forms ahead of time that are available on our website (www.rocklinoralsurgery.com) and bring them in with you.
 4. List of current medications.
- A pre-operative consultation and physical examination is required for patients undergoing general IV anesthesia for surgery.
- The initial visit with the exception of certain emergency cases, is for consultation only. This enables us to fully evaluate the area of concern and tailor the care to your specific needs.
- Minors must be accompanied by a parent or legal guardian.
- If you are unable to keep your appointment for any reason, please contact us within 48 hours of your scheduled appointment.

Appointment: Month _____ Day _____ Time _____

OFFICE MAP



PATIENT INSTRUCTIONS

You have been referred for specialized care with an Oral and Maxillofacial Surgeon. We seek to provide the highest quality oral surgery services for your individual needs. Please assist us by providing the following information at the time of your consultation.

- The day of your appointment please bring:
 1. This referral slip.
 2. Current x-rays (if available).
 3. Insurance cards (if you have them). You may also fill out the Patient Registration forms ahead of time that are available on our website (www.rocklinoralsurgery.com) and bring them in with you.
 4. List of current medications.
- A pre-operative consultation and physical examination is required for patients undergoing general IV anesthesia for surgery.
- The initial visit with the exception of certain emergency cases, is for consultation only. This enables us to fully evaluate the area of concern and tailor the care to your specific needs.
- Minors must be accompanied by a parent or legal guardian.
- If you are unable to keep your appointment for any reason, please contact us within 48 hours of your scheduled appointment.

Appointment: Month _____ Day _____ Time _____