CAROLINAS CENTER FOR
ORAL & FACIAL SURGERY
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Orthognathic Referral Form

Upon submission of the completed form, you will be given the opportunity to upload X-rays and print or save a copy of this form for your records.

Patient _____ Date of Birth _____
FIRST NAME LAST NAME

Parents *(if minor)* _____

Phone (Home) ( ) _____ (Cell) ( ) _____

Address _____
STREET CITY STATE ZIP

Email _____

Orthognathic Specialists

☐ **BILLINGSLEY RD.—CHARLOTTE**
- ☐ Bart C. Farrell, DDS, MD
- ☐ Brian B. Farrell, DDS, MD, FACS
- ☐ Waheed V. Mohamed, DDS, MD

☐ **BLAKENEY/BALLANTYNE**
- ☐ Brian B. Farrell, DDS, MD, FACS
- ☐ Richard A. Kapitan, DDS, MS, FACS
- ☐ John C. Nale, DMD, MD, FACS

☐ **CONCORD**
- ☐ Nicholas J. Kain, DDS

☐ **GREENVILLE**
- ☐ Jim W. Howell, DMD

☐ **LAKE NORMAN/DENVER**
- ☐ Daniel R. Cook, DDS, MD

☐ **ROCK HILL**
- ☐ John H. Wessel, DMD, MD

☐ **UNIVERSITY—CHARLOTTE**
- ☐ Peter B. Franco, DMD, FACS

Orthognathic & Treatment Planning

C.C. & Orthodontic Assessment _____

_____

Orthognathic Surgery

Maxillary Surgery
- ____ LeFort 1 Osteotomy
- ____ LeFort 1 Segmental
- ____ Nasal

Mandibular Surgery
- ____ Mandibular Advancement
- ____ Mandibular Setback
- ____ Chin Surgery

Additional Comments

_____

_____

Referring Doctor _____ Phone Number _____ Date _____