



CHESAPEAKE

Oral Surgery & Dental Implants

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REFERRAL FORM

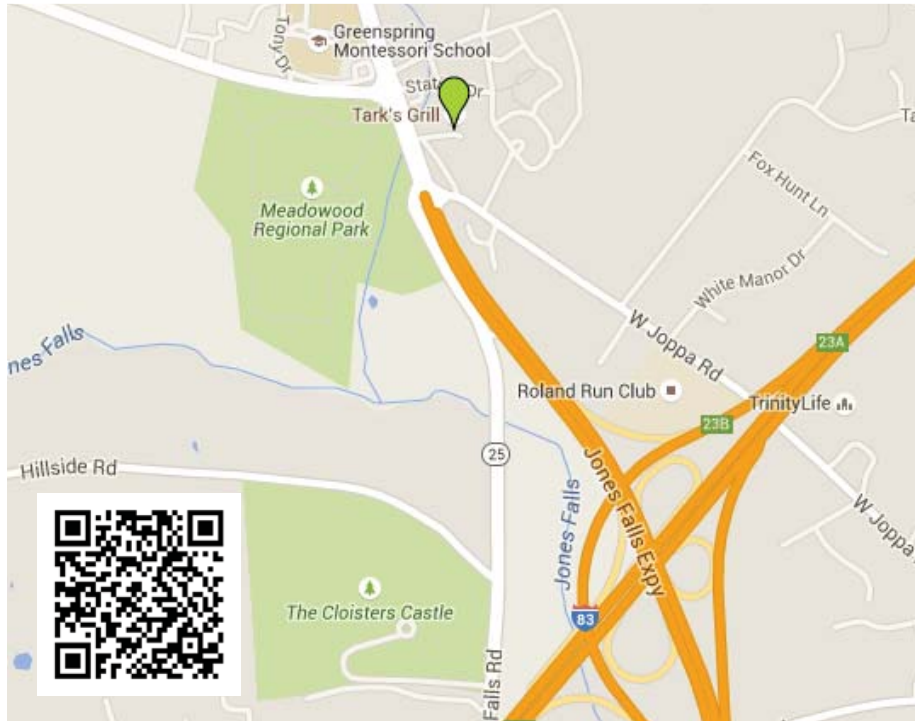
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PATIENT: _____

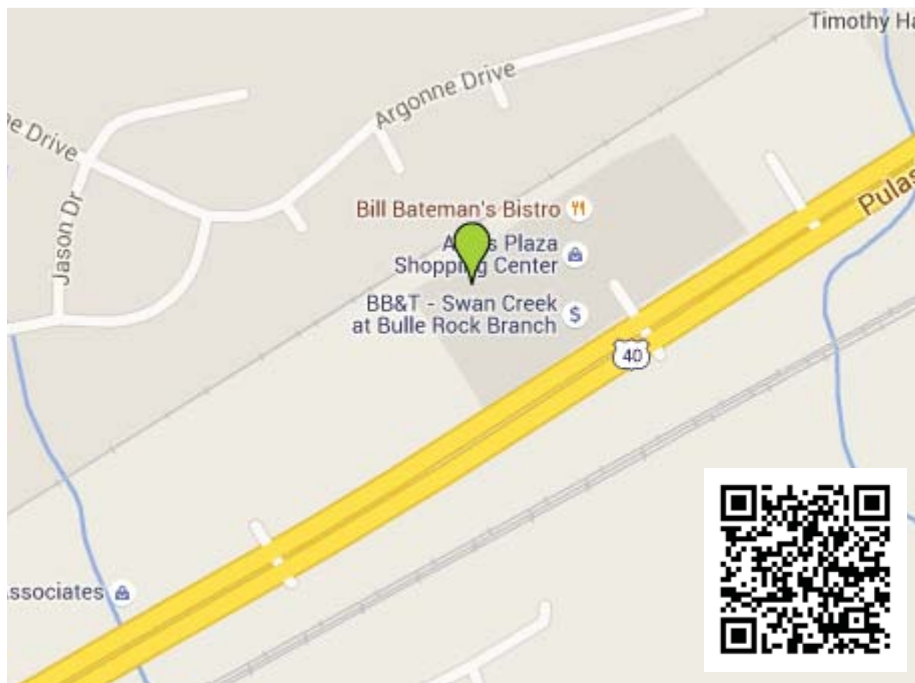
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TREATMENT NEEDED: _____

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