



NICOLETTE ESSIAN, DMD, CFNC, MS
 ORAL & MAXILLOFACIAL PATHOLOGIST

PATHOLOGY REFERRAL FORM
YOU MUST BRING THIS TO YOUR CONSULTATION

·Please send any recent xrays/images via email·

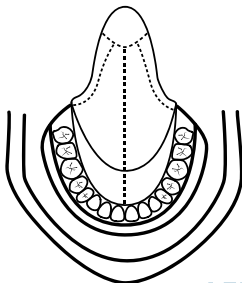
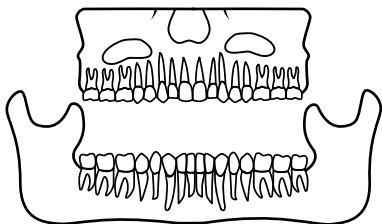
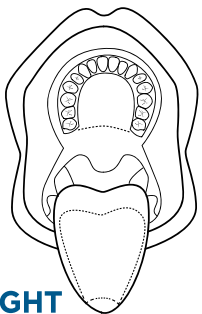
Patient's Name: _____

DOB: _____ Today's Date: _____

Referred By: _____

Referral Address: _____

·Please Circle The Area To Be Treated/Evaluated·



RIGHT

TREATMENT REQUESTED

LEFT

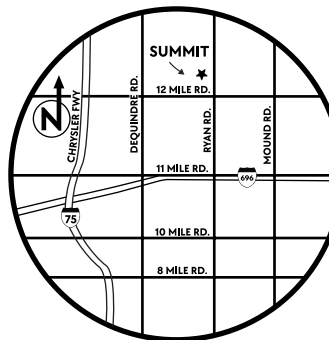
- Laser Ablation (Rochester Location) Consultation Based Management (Biopsy Proven Dysplasia)
- TMJ Evaluation/Botox Lesion Evaluation
- Biopsy
 - Location _____
 - Size _____
 - Symptoms _____
 - Duration _____
- Comments/Other: _____

·Please have your insurance info ready when scheduling your appointment·
 ·CHILDREN UNDER 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN·

www.summitfacial.com

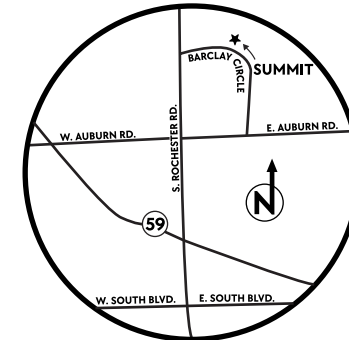
PROVIDING SPECIALIZED ORAL PATHOLOGY CARE AT THESE LOCATIONS:

WARREN STERLING HEIGHTS



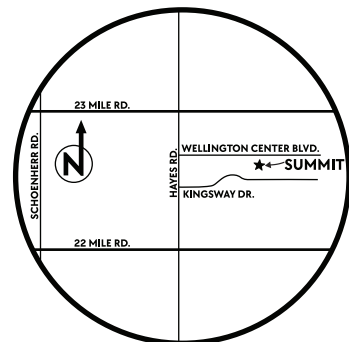
ADDRESS: 29427 Ryan Rd.
 Warren, MI 48092
PHONE: 586-755-9340
FAX: 586-755-1081
EMAIL: WAR@SUMMITFACIAL.COM

ROCHESTER TROY



ADDRESS: 305 Barclay Circle Dr. #1000
 Rochester Hills, MI 48307
PHONE: 248-293-5500
FAX: 248-293-5505
EMAIL: ROCH@SUMMITFACIAL.COM

MACOMB CLINTON TOWNSHIP



ADDRESS: 15286 Wellington Center Blvd.
 Macomb, MI 48044
PHONE: 586-286-1600
FAX: 586-286-8963
EMAIL: MAC@SUMMITFACIAL.COM