



NICOLETTE ESSIAN DMD, CFNC, MS
ORAL & MAXILLOFACIAL PATHOLOGIST

ORAL PATHOLOGY REFERRAL FORM

- You must **bring this referral form with you to your appointment.**
- Have your **insurance and referral ready** when scheduling your appointment.
- **Children under 18** must be accompanied by a parent or legal guardian.

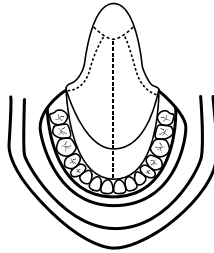
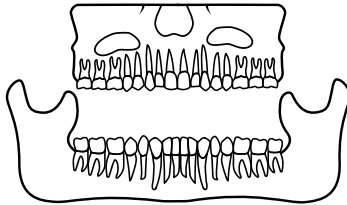
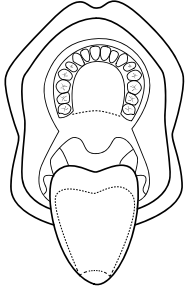
Patient's Name: _____

DOB: _____ Today's Date: _____

Referred By: _____

Referral Address: _____

Images to be sent to frontdesk@summitfacial.com? ☐ Yes ☐ No
Please **Circle** The Area To Be Treated/Evaluated



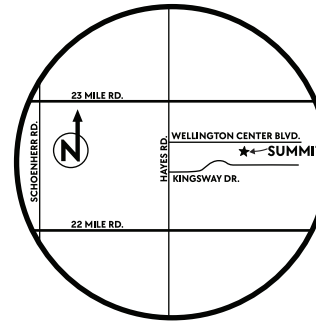
TREATMENT REQUESTED

- ☐ Laser Ablation
- ☐ TMJ Evaluation/Botox
- ☐ Biopsy
 - Location _____
 - Size _____
 - Symptoms _____
 - Duration _____
- ☐ Consultation Based Management
- ☐ Lesion Evaluation
- ☐ Comments/Other: _____



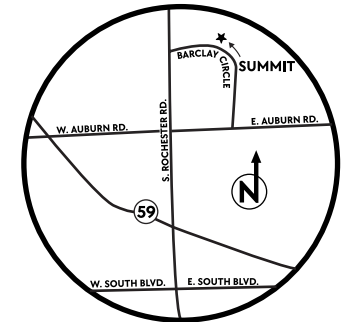
To ensure a seamless visit, we kindly request you **complete** your **patient registration** prior to your visit. You may access the online portal by scanning the **QR code** or by visiting www.summitfacial.com.

OFFICE LOCATIONS



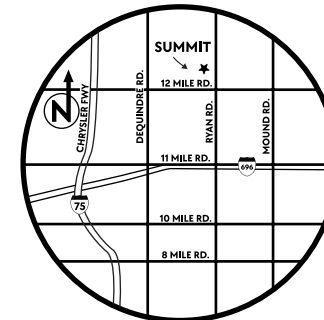
MACOMB/CLINTON TOWNSHIP

Address: 15286 Wellington Center Blvd.
Macomb, MI 48044
Phone: 586-286-1600 **Fax:** 586-286-8963



ROCHESTER/TROY

Address: 305 Barclay Circle Dr. • #1000
Rochester Hills, MI 48307
Phone: 248-293-5500 **Fax:** 248-293-5505



WARREN/STERLING HEIGHTS

Address: 29427 Ryan Rd.
Warren, MI 48092
Phone: 586-755-9340 **Fax:** 586-755-1081

Send Digital Images & Referral Forms to: frontdesk@summitfacial.com