



WESTERN OMS

ORAL AND MAXILLOFACIAL SURGERY

Dr Franc R C Henze
Consultant Oral & Maxillofacial Surgeon

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PATIENT INFORMATION

Date: _____

Name: _____

Date of birth: _____

Address: _____

Phone: _____ Email: _____

THIS PATIENT IS REFERRED FOR THE FOLLOWING TREATMENT

Removal of wisdom teeth

Removal of teeth / root remnants

Dental implants

Pathology

Other conditions

REFERRER'S DETAILS

Referrer's name: _____

Referrer's provider number: _____

Address: _____

Phone: _____ Email: _____