Referral

Referring Doctor

Date

Patient Name: ____________________________

Patient Phone Number: ________________________________

Referring For: ________________________________

Radiographs:  ○ given to patient  ○ sent by mail  ○ e-mailed  ○ needed
Instructions to patients:

1. Please call 480.515.5400 to schedule your first appointment.

2. Generally your care is provided in three separate visits:
   - examination and consultation
   - the surgical procedure
   - an exam after surgery

3. A parent or legal guardian must accompany minors.

4. Bring this slip with you on your first visit.

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Cosmetic, Facial, Oral Surgery & Med Spa

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