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Board-Certified

Oral Maxillofacial & Implant Surgery

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INTRODUCING: _____

PATIENT PHONE NUMBER _____

REFERRAL IS THE COURTESY OF: _____

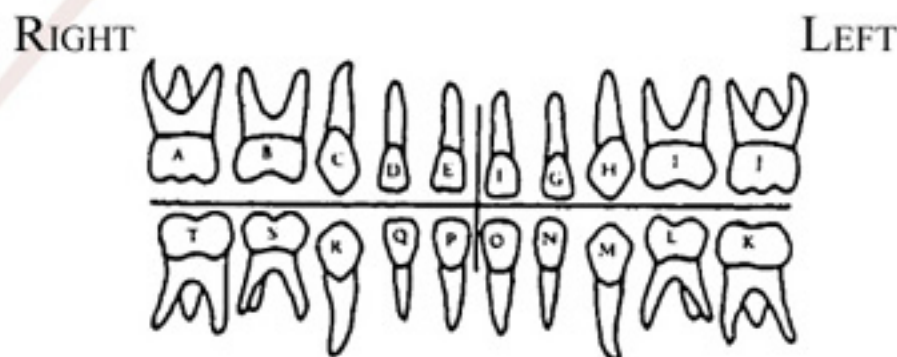
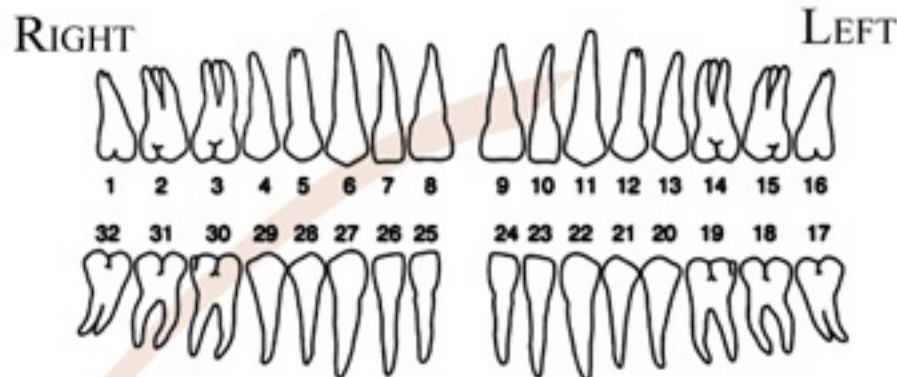
DATE: _____

Please Evaluate:

- | | | |
|---|---|---|
| <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Implant | <input type="checkbox"/> Bone Graft |
| <input type="checkbox"/> Minimally Invasive Extractions | <input type="checkbox"/> Soft Tissue Graft | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Infection / Incision, Drainage | <input type="checkbox"/> Biopsy / Pathology | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Assist Ortho: Exposure / Bracket / Implant Anchorage | | |
| <input type="checkbox"/> PLEASE CALL Referring Doctor | | |

Notes: _____

PLEASE INDICATE TEETH/AREA TO BE TREATED



Dear Patient:
 Your first visit will include a consultation with the doctor. In most cases, a consultation visit is required first and then a separate date for the procedure is scheduled. Please be prepared to discuss your medical history and details of any medication you are taking.

Are you considering sedation, sleeping, or medical relaxation? If so, please see the instructions on the back of this form.

Your appointment is time specially reserved for you. If you cannot keep your appointment, please call us at least 24 hours in advance.