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ELEVATED
ORAL SURGERY · DENTAL IMPLANTS · FACIAL AESTHETICS

PATIENT INFORMATION:

Today's Date_____

First Name_____ Last Name _____ Date of Birth_____

Parent / Guardian Name_____

Contact Telephone _____Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No • ❑ Patient will call for appointment ❑ Please call patient

Treatment_____

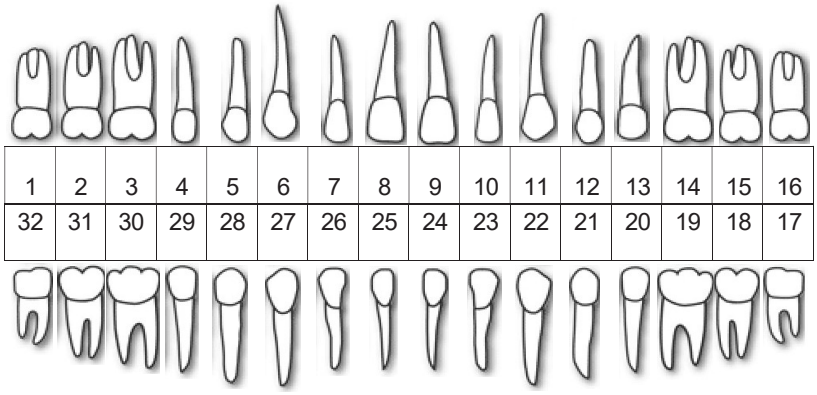
REFERRING DOCTOR'S INFORMATION:

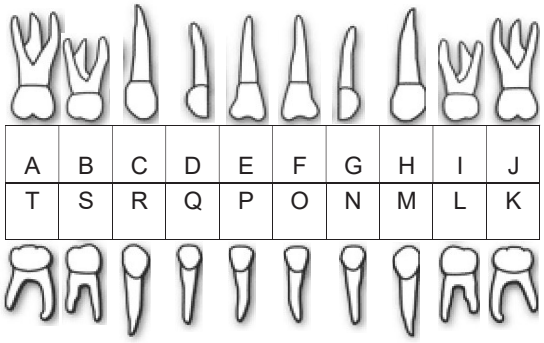
Referred By_____ Telephone _____

E-Mail Address _____

PROCEDURES:

❑ Extraction (see below)
❑ Alveoplasty
❑ Biopsy
❑ Exposure
❑ Hard Tissue
❑ Infection
❑ Frenectomy
❑ Apicoectomy
❑ Other _____
❑ Incision & Drainage
❑ Lesion Evaluation
❑ Expose &Bond
❑ Soft Tissue





Please Specify Teeth For Extraction _____

CONSULTATIONS:

❑ TMJ
❑ Implants: ❑ Immediate ❑ Delayed
❑ Orthognathic Evaluation
❑ Pre–Prosthetic
❑ Cleft Lip & Palate
❑ Cosmetic
❑ Ridge Augmentation
❑ Oral / Facial Lesion
❑ Bone Grafting
❑ Other

RADIOGRAPHS OR CLINICAL PHOTOS:

❑ Being Mailed
❑ Given to Patient
❑ Please Take
❑ No X–Ray
❑ Attached With This Referral; if X-Rays are attached, what date were they taken_____

CASE NOTES: