



**Patient Consultation/Surgery Referral**

DOCTOR

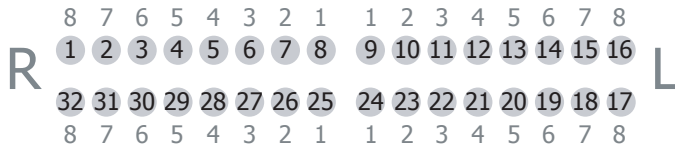
DATE TEL

**DATES:** Please evaluate for following surgeries

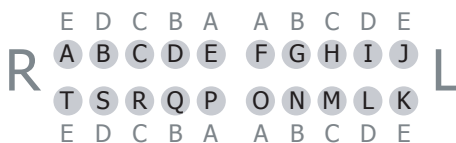
- As soon as possible.
- Please call before surgery.
- Perform on or about:

**EXTRACTION:** Please cross out teeth that needs to be extracted.

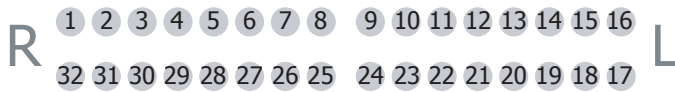
PERMANENT



PRIMARY



**IMPLANT:** Please mark the area that requires implant.



BRAND

- Nobel/Branemark
- 3i
- Astra
- Straumann

METHOD

- Site Preservation
- Immediate implant
- Immediate loading
- Please call

**WELCOME TO OUR OFFICE!**

Our office is committed to providing you with the highest quality of care possible. The following consultation/surgery is requested by your doctor. If by necessity, you must change your appointment, please notify us at least 2 days in advance.

Pre-registering at [www.prestonoralsurgery.com](http://www.prestonoralsurgery.com) would significantly reduce amount of time for check-in process. It is directly linked to our patient management system via secured connection.

PATIENT AGE

CONTACT NUMBER

**ORAL SURGERY:**

- Oral/Facial Lesion
- Gingival/Bone Graft
- Ridge/Tori Reduction
- Vestibuloplasty
- Odontogenic Infection
- Exposure of teeth
- Other

**MAXILLOFACIAL SURGERY:**

- Facial Fractures
- Skeletal Malocclusion
- TMJ Evaluation
- Facial Deformity
- Biopsy/Pathology
- RPE/Bone Anchor
- Other

**ADDITIONAL INFORMATION:**

Please feel free to write any instruction that might benefit the care of this patient. Thank you.

**RADIOGRAPHS**

- Please take any required radiographs.
- Enclosed are the patient's X-rays
- PLEASE RETURN them, as they are part of our permanent records.

SIGN DATE

