Oral and Maxillofacial Surgery Associates of Western New York, P.C.

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www.oralsurgeryofwny.com

*Diplomate, American Board of Oral & Maxillofacial Surgeons

PATIENT NAME: _____

DATE: _____

The above patient has been referred to your office for the following:

___ Extractions
___ Surgical Exposures
___ Lesion Evaluation
___ Implant Consultation
___ TMJ Evaluation
___ Orthognathic Consultation

			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

Please list other procedures which need to be accomplished or pertinent information on this patient:

_____

_____

_____

_____

REFERRING DOCTOR NAME: _____

PHONE: _____

X-RAYS MAILED OR BROUGHT BY PATIENT: _____ **PANOREX** _____ **PA** _____ **OTHER**

Patient Instructions:

1) Minors must be accompanied by parent or legal guardian.
2) Certain cases require an appointment for consultation prior to surgery.
3) Please give at least 24 hours notice of appointment cancellation.
4) If possible, please fill out insurance information and medical history forms which can be found on our website:

www.oralsurgeryofwny.com

5) Patient anticipating intravenous sedation, **MUST NOT HAVE ANYTHING TO EAT OR DRINK 6 HOURS PRIOR** to surgery. A driver must wait in the waiting room until surgery is complete.

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Fax: 716-668-2447

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