CHINOOK
ORAL & MAXILLOFACIAL SURGERY

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

REFERRING DOCTOR'S INFORMATION:

Referred By ____________________ Telephone ____________________

E-Mail Address ____________________

REASON FOR REFERRAL:

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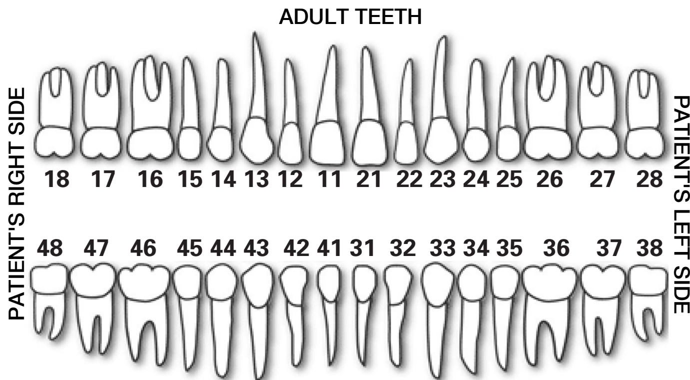
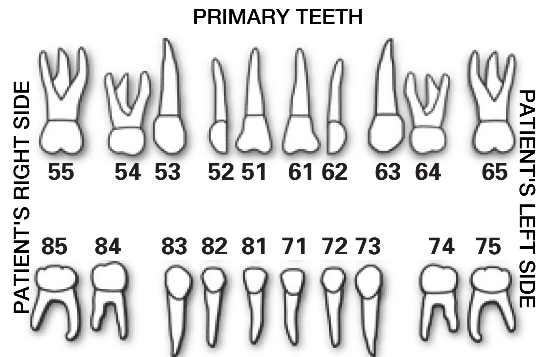
CROSS OUT ANY TEETH TO BE EXTRACTED WITH AN X:





Please Verify Teeth ____________________

RADIOGRAPHS OR CLINICAL PHOTOS:

❏ Being Mailed
❏ Given To Patient
❏ Please Take
❏ No X–Ray

If X-Rays are attached, what date were they taken ____________________

INSURANCE INFORMATION OR ADDITIONAL COMMENTS:

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Signature of Referring Dentist/Physician: ____________________

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