CHINOOK
ORAL & MAXILLOFACIAL SURGERY

PATIENT INFORMATION:

Today's Date: _____

First Name _____ Last Name _____

Date of Birth: Day_____ Month _____Year_____ Sex: ❑ Male ❑ Female

Parent / Legal Guardian Name_____ Relationship to Patient _____

Contact Home Telephone (_____) _____ Cell (_____) _____ Other (_____) _____

Contact E-Mail_____

Contact Mailing Address _____

REFERRING DOCTOR'S INFORMATION:

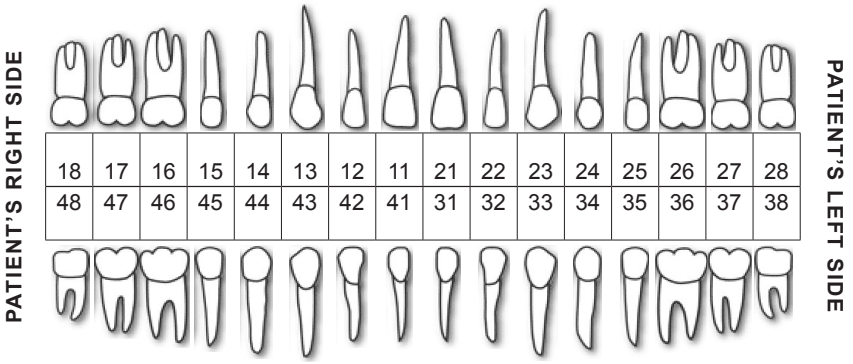
Referred By_____ Telephone _____

Referring Doctor's E-Mail _____

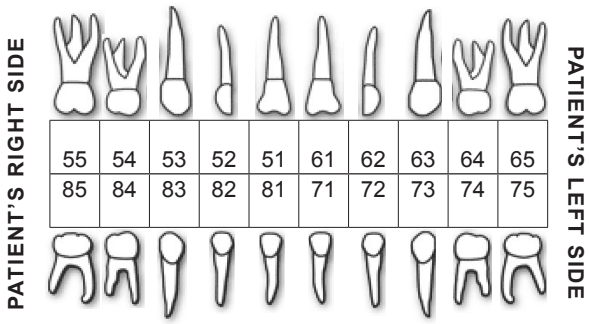
REASON FOR REFERRAL / ADDITIONAL COMMENTS:

CHECK ANY TEETH TO BE EXTRACTED:

ADULT TEETH



PRIMARY TEETH



Please Verify Teeth For Extraction_____

RADIOGRAPHS OR CLINICAL PHOTOS:

❑ Being Mailed ❑ E-Mailed ❑ Pano / PAs ❑ CBCT ❑ Photos ❑ Please Take

If X-Rays / photos are attached, what date were they taken: Day_____ Month_____Year_____

INSURANCE INFORMATION:

Policy Holder _____

Birthdate: Day_____Month _____Year_____

Relation _____

Insurance Company _____

Group / Plan_____

ID / Certificate _____

Policy Holder _____

Birthdate: Day_____Month _____Year_____

Relation _____

Insurance Company _____

Group / Plan_____

ID / Certificate _____

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