Treatment Order

Oral & Facial Surgery Associates, Inc

Dennis A. Perry, D.M.D. J. David Morrison, D.M.D. Glenn S. Waters, D.D.S.

10506 Montgomery Road
Suite 203
Cincinnati, OH 45242
(513) 791-0550
Fax (513) 791-1517
www.omscincinnati.com
info@omscincinnati.com

Reason for Referral:

- ❑ **Implants:** _____
  Implant Preferences: _____
- ❑ **Extractions:** _____
- ❑ **Biopsy/Pathology**
  Site: _____
- ❑ **Orthodontic Tx**
  Expose _____
  Bond _____
- ❑ **Other Instructions:**

Date: _____

Patient: _____
FIRST NAME LAST NAME

Date of Birth: _____

Referred by Doctor: _____

Visiting: ❑ Dr. Perry ❑ Dr. Morrison ❑ Dr. Waters

Please Circle Teeth to be Treated:

Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16 Left
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

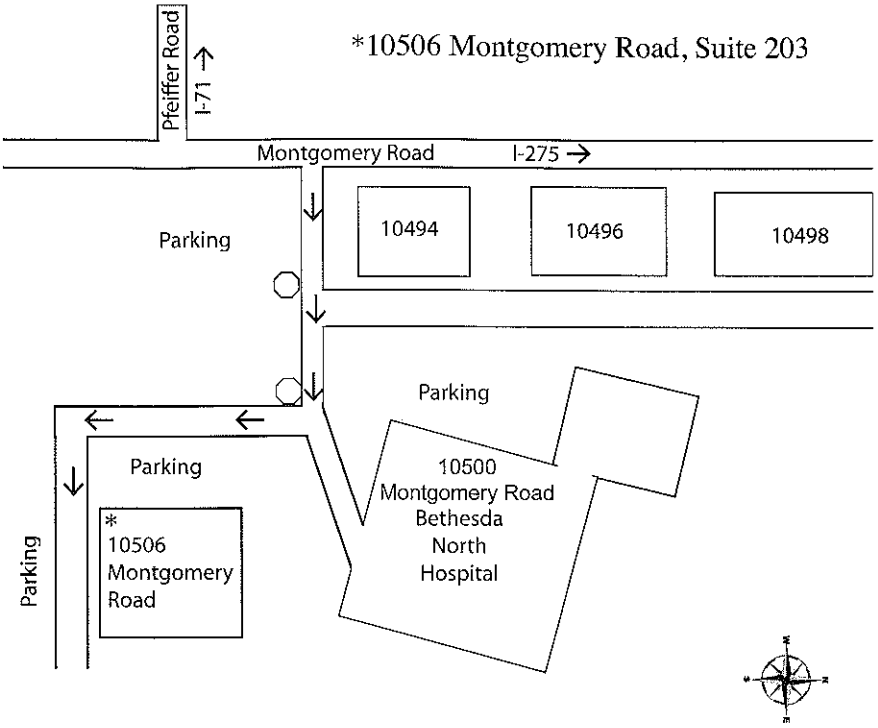
Right	A	B	C	D	E	F	G	H	I	J	Left
	T	S	R	Q	P	O	N	M	L	K	

INSTRUCTIONS TO PATIENTS

You have been referred to our office for specialized care with an oral and maxillofacial surgeon. A pre-operative consultation is necessary for all patients prior to undergoing surgery. Our office will make every effort to make your visit with us a comfortable and pleasant experience. To facilitate your initial consultation please provide the following information:

- Your surgical treatment order and any x-rays if applicable.
- A list of medications you are presently taking.
- If you have medical or dental insurance, bring the necessary information, cards or forms. This will save time and allow us to help you process any claims.

IMPORTANT: Patients under the age of 18 must have a parent or legal guardian present to give written consent for treatment.



If you are unable to keep your appointment, please give us the courtesy of 48 hours advance notice.
Thank you for your consideration.