

S. Matthew Davis, DDS, MD

Diplomate, American Board of Oral and Maxillofacial Surgery

Phone: 651.760.3681 Fax: 651.309.8755

www.thedentalspecialists.com

241 Radio Drive, Suite A, Woodbury, MN 55125

Date _____

Patient Name _____

Phone _____

- For:
- Extractions
 - Trauma/Facial Fractures
 - Alveoloplasty
 - Orthognathic Evaluation/Treatment
 - Biopsy
 - Radiation Therapy Oral Evaluation
 - Facial Pain
 - TMJ Evaluation/Treatment
 - Implants
 - Pre-prosthetic Evaluation/Treatment
 - Panorex
 - Pathology Consultation
 - Sleep Apnea
 - Facial and Cosmetic Surgery

Remarks: _____

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

PATIENTS HAVING INTRAVENOUS SEDATION (patient asleep)
MUST NOT HAVE any food or fluids for six hours before surgery, and
MUST HAVE an adult accompany them and remain in the office.

Appointment Date _____ Time _____

Referring Doctor _____

Referring Practice _____

Email _____

Phone _____

Fax _____

