# S. Matthew Davis, DDS, MD

*Diplomate, American Board of Oral and Maxillofacial Surgery*

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Date _____

Patient Name _____

Phone _____

For:

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

Remarks: _____

_____

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 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 | |
| **RIGHT** | | | | | | | | | | | | | | | | | **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 _____

TDS THE DENTAL SPECIALISTS

ORAL & MAXILLOFACIAL SURGERY