

# Marvin A. Vallejo, DMD, MD

*Specialist in Oral & Maxillofacial Surgery*

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Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

- For:
- |  |  |
|--|--|
| <input type="checkbox"/> Extractions   | <input type="checkbox"/> Trauma/Facial Fractures             |
| <input type="checkbox"/> Alveoloplasty | <input type="checkbox"/> Orthognathic Evaluation/Treatment   |
| <input type="checkbox"/> Biopsy        | <input type="checkbox"/> Radiation Therapy Oral Evaluation   |
| <input type="checkbox"/> Facial Pain   | <input type="checkbox"/> TMJ Evaluation/Treatment            |
| <input type="checkbox"/> Implants      | <input type="checkbox"/> Pre-prosthetic Evaluation/Treatment |
| <input type="checkbox"/> Panorex       | <input type="checkbox"/> Pathology Consultation              |
| <input type="checkbox"/> Sleep Apnea   | <input type="checkbox"/> 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 \_\_\_\_\_

