

Marvin A. Vallejo, DMD, MD

Diplomate, American Board of Oral & Maxillofacial Surgery

Phone: 952.746.5231 Fax: 952.236.4959

www.thedentalspecialists.com

☐ 6545 France Ave S Suite 366, Edina, MN 55435

☐ 18258 Minnetonka Blvd, Suite 100, Wayzata, MN 55391

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: _____

RIGHT																	LEFT
	1	2	3	A	B	C	D	E	F	G	H	I	J	14	15	16	
	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
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SURGERY