ORAL FACIAL IMPLANT SURGERY

Drs. Bailey, Peoples & Oghalai, P.A.

Board Certified Oral & Maxillofacial Surgeons

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☐ **Paul H. Bailey, D.D.S.**
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☐ **Mark A. Oghalai, D.D.S.**

Today's Date ____________________________

Patient Name: ____ Patient DOB: _________________________
Parent/Guardian: ____ Daytime Phone: _______________________
Appointment Date: ____ Time: _______________________________

Referring Doctor: ____ Office Phone: ________________________

Referral Information:

_____ Consult
_____ Extraction
_____ Other

Radiographs:

_____ Enclosed
_____ Desired
_____ Mailed
_____ Emailed
(xrays@omfsurgeons.com)

Implant Treatment Planning

_____ Individual Teeth ______________________
_____ Bridge _____________________________
_____ Full Arch: ____ Maxillary _____ Mandibular
_____ Fixed Hybrid Prosthesis ______________
_____ Conus Prosthesis ___________________
_____ Locator Prosthesis __________________

Implant Systems

_____ Astra Tech EV ______ Ankylos

Remarks: ____
____
____

(Please note <u>IF</u> IV Sedation is used: No food or drink 8 hours prior to the appointment, please wear short sleeves or loose clothing; a driver <u>MUST</u> come and <u>STAY</u> in the lobby until the surgery is finished and to drive the patient home afterwards.)

Please Circle the Tooth Number

Right **Permanent Teeth** **Left**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary Teeth

A B C D E F G H I J

T S R Q P O N M L K

Please refer to our practice website for additional information regarding oral surgical procedures and post-operative information at www.omfsurgeons.com. There are also registration forms that can be printed and completed prior to the appointment.

Maps & Directions on Back of Referral Form