



Date: _____

Patient's Name: _____

Patient's Phone: _____

Referred by Doctor: _____

REASON FOR REFERRAL

- Implants / Bone Graft
- Oral Pathology
- Extractions
- Wisdom Teeth
- Exposure & Bonding
- Anterior Apicoectomy

Other: _____

IF FOR EXTRACTION, PLEASE CIRCLE TEETH TO BE EXTRACTED

(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
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
(T S R Q P								Q N M L K)							

Please bring with you:

- Photo ID
- Current X-rays
- A list of allergies and medications

- Medical and dental insurance cards
- Name and contact info for your physicians

IMPORTANT NOTICE: If general anesthesia or intravenous sedation is used, the patient must have **ABSOLUTELY NOTHING TO EAT OR DRINK** for at least 8 hours before the appointment. It is required that the patient be accompanied by an adult, present in the office, for the duration of the procedure and recovery.

CHESAPEAKE DENTAL SPECIALISTS