Dental Surgeons Ltd
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Patient Name:_____ Phone:_____

REASON FOR REFERRAL:

_____ Extraction (Mark below) _____ Biopsy _____ Implant

_____ TMJ _____ CBCT _____ Expose and Bond

PERMANENT DENTITION

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 DENTITION

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

OTHER:

REFERRING DENTIST: (Send X-rays with patient or email)
Name:_____ Address:_____ City:_____ State ___ Zip Code:_____
Email address:_____Phone:_____

Your first visit is NOT guaranteed to include surgery. A consultation is REQUIRED prior to sedation. DO NOT EAT any solid food or liquids eight (8) hours and NO CLEAR LIQUIDS 4 (four) hours prior to your SEDATION.
ALL SEDATED PATIENTS must be at our office with a responsible adult/parent/guardian that STAY in office and drive you home.

IF YOU TAKE PRESCRIPTION MEDICATIONS: **Take your oral medications as usual.** Bring your medications or a list of them to your appointment. Minors must be with a parent or legal guardian. If you are unable to keep your appointment, please notify the office as soon as possible. The fee for services is due at the time of surgery unless other arrangements were made.