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SURGERY CENTER™

Specialists in Oral and Maxillofacial Surgery

Joseph R. Deatherage, D.M.D., M.D.

Preston A. Gomez, D.D.S.

Michael R. Knoll, D.D.S., M.D.

Derek M. Miller, D.D.S.

Date: _____

Patient: _____ Birth Date: _____

Parent/Legal Guardian: _____

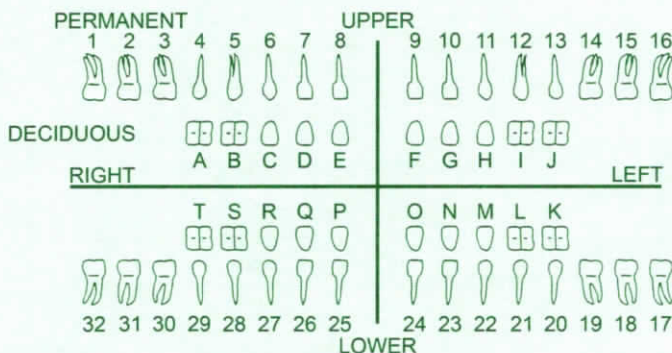
Address: _____

Telephone No. H: _____ W: _____

Cell Phone: _____

Referred by Dr.: _____

If teeth are to be removed, please indicate on the chart below.



- | | | |
|---|--|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Immediate Denture | <input type="checkbox"/> Treatment of Cyst or Tumor |
| <input type="checkbox"/> Implant | <input type="checkbox"/> Apicoectomy | <input type="checkbox"/> Soft Tissue Biopsy |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Surgical Exposure of Impacted Teeth | <input type="checkbox"/> Removal of Tori |
| <input type="checkbox"/> Orthognathic | <input type="checkbox"/> Removal of Hyperplastic Tissue | <input type="checkbox"/> General Anesthesia or IV Sedation |
| <input type="checkbox"/> Extraction | | <input type="checkbox"/> Local Anesthesia |
| <input type="checkbox"/> Surgical Impaction | | |
| <input type="checkbox"/> Alveoloplasty | | |

Patient should not have food or fluids after midnight or 6 hours before coming to the office for a general anesthetic.

X-RAYS Sent You Take Sent with Patient No x-rays

Patient has been requested to contact your office.

Please contact this patient.

Patient has appt. on: _____

REMARKS: _____

BISMARCK

