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**SURGERY CENTER™**

*Specialists in Oral and Maxillofacial Surgery*

Charles A. Crago, D.M.D., M.D., F.A.C.S.  
 Omar C. Chahal, D.D.S., M.D., M.B.A.  
 Jonathan R. Gray, D.D.S.

**Date:** \_\_\_\_\_

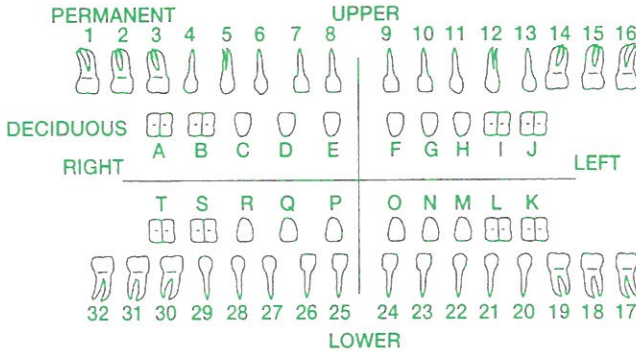
**Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Home:** \_\_\_\_\_

**City, State:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Referred by Dr.:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

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



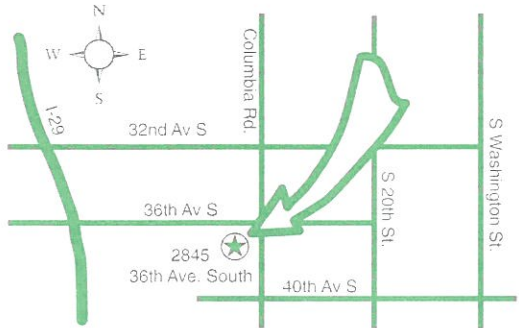
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Consultation       | <input type="checkbox"/> Apicoectomy                         | <input type="checkbox"/> Soft Tissue Biopsy                |
| <input type="checkbox"/> Implant            | <input type="checkbox"/> Repair of Traumatic Injury          | <input type="checkbox"/> Removal of Tori                   |
| <input type="checkbox"/> TMJ                | <input type="checkbox"/> Surgical Exposure of Impacted Teeth | <input type="checkbox"/> General Anesthesia or IV Sedation |
| <input type="checkbox"/> Orthognathic       | <input type="checkbox"/> Removal of Hyperplastic Tissue      | <input type="checkbox"/> Local Anesthesia                  |
| <input type="checkbox"/> Extraction         | <input type="checkbox"/> Treatment of Cyst or Tumor          |  |
| <input type="checkbox"/> Surgical Impaction |  |  |
| <input type="checkbox"/> Alveoplasty        |  |  |
| <input type="checkbox"/> Immediate Denture  |  |  |
- X-Rays**
- Dr. to send
  - Sent with patient
  - Take at your office

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

- Patient has been requested to contact your office.
- Please contact this patient.
- Patient has appt. on: \_\_\_\_\_

**REMARKS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## GRAND FORKS



## FARGO

