KELOWNA ORAL & FACIAL SURGERY

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Kelowna BC
V1Y 0G1

PATIENT INFORMATION

Name: _____ Guardian *(if applicable)*: _____

Address: _____ Gender: ☐ Male ☐ Female

Email: _____ Phone: _____ Date of Birth: D / M / Y

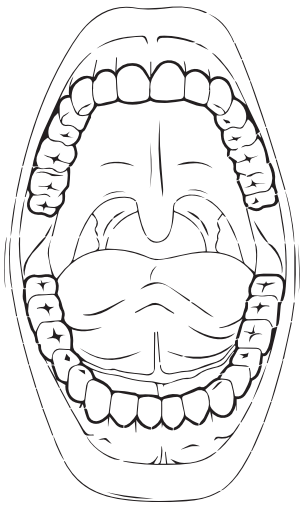
REFERRING DOCTOR

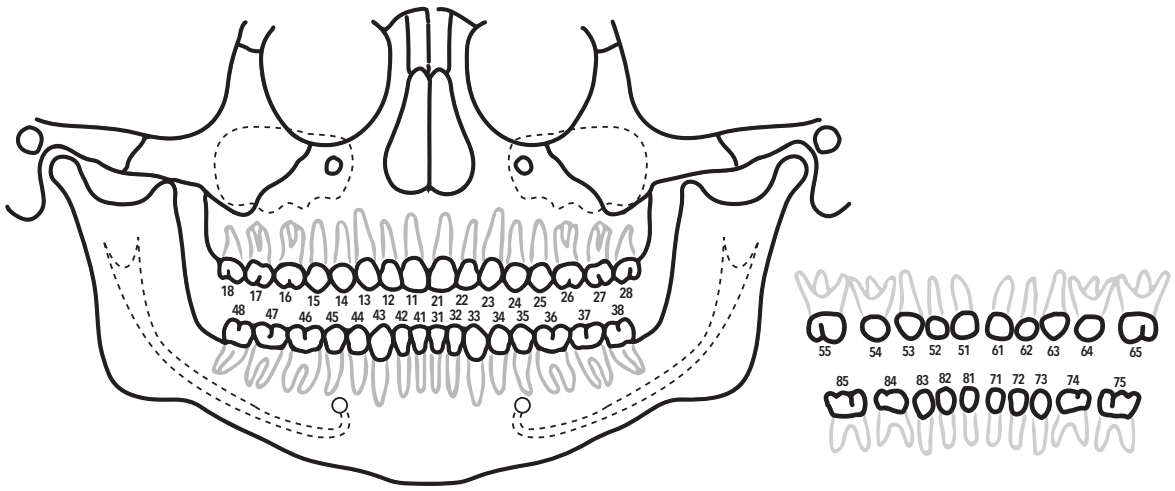
Name/Office _____ Office Phone: _____

Today's Date: D / M / Y ☐ Please call patient to schedule ☐ Patient will call to schedule

Radiographs / Photos: ☐ Emailed ☐ Mailed ☐ Patient Will Bring ☐ Please Take New Ones

Tooth #'s or areas to be treated *(please also indicate on diagram)*: _____





PROCEDURE(S) OR CONSULTATIONS REQUESTED

☐ Extractions: Discuss replacement with dental implant(s)? ☐ Yes ☐ No

☐ Preprosthetic (Alveoplasty, frenectomy, etc.)

☐ Trauma ☐ TMD / Facial Pain ☐ Pathology/Biopsy

☐ Cleft Lip and Palate ☐ Exposure / Bond

☐ Orthognathic Surgery

☐ Other _____

DENTAL IMPLANTS

Implant Type: ☐ Straumann ☐ Astra ☐ Nobel ☐ Other

☐ Digital Implant Impression Lab: _____

Full Arch: ☐ Fixed ☐ Removable ☐ Upper ☐ Lower

Would you like us to fabricate and insert the immediate provisional?

☐ Yes ☐ No

MANAGEMENT, MEDICAL OR TREATMENT COMMENTS

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