

REFERRAL TO: Dr. Martyna Dr. Wong No Preference

PATIENT INFORMATION

Name: _____ Guardian (if applicable): _____

Address: _____ Sex: Male Female

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

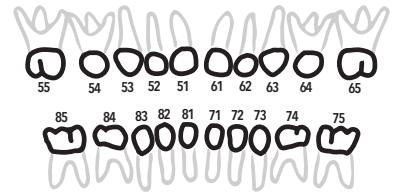
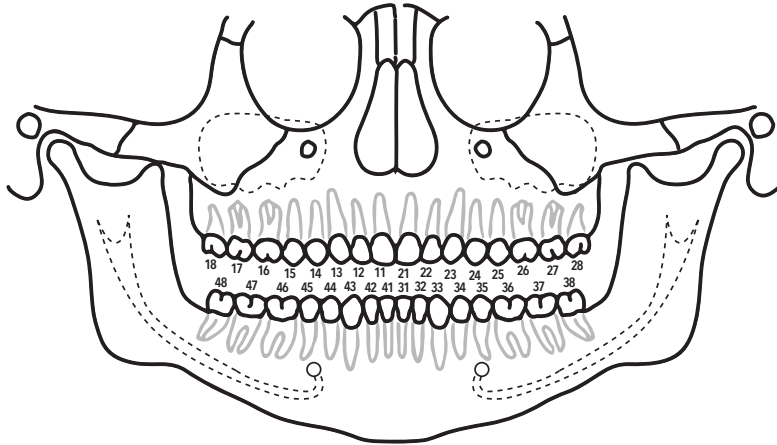
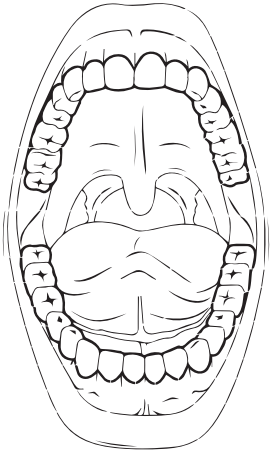
REFERRING DOCTOR

Name/Office: _____ Office Phone: _____

Today's Date: / / 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 Pathology/Biopsy
- Cleft Lip and Palate Exposure / Bond
- Orthognathic Surgery
- Other _____

MANAGEMENT, MEDICAL OR TREATMENT COMMENTS

DENTAL IMPLANTS

Implant Type: Straumann Astra Nobel Other
 Digital Implant Impression Lab: _____
Immediate provisional will be provided by:

TO OUR VALUED PATIENTS:

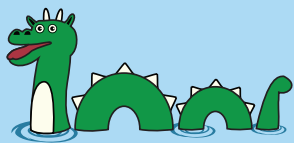
Your appointment is time specifically reserved for you. If you cannot keep your appointment, please inform the office 3 days in advance so the time may be given to another patient. For new patients, **please fill out the 'Patient Intake Form' online** (www.kelownaoralsurgery.com/forms) or arrive 15 minutes prior to your scheduled appointment.

For patients to be sedated during surgery (Please coordinate with our office ahead of time):

1. Do not eat or drink anything the day of your surgery. A sip of water may be taken with approved medications.
2. Clean your teeth and mouth well prior to surgery.
3. Arrange for a responsible adult to accompany you and to drive you home. Your driver must be present when you check in for your appointment.

Parking is available on site, and is free for patients.

Please call us or visit our website for additional resources at:
KELOWNAORALSURGERY.COM



Lake Okanagan

