William L. Cecere III, DDS, MD

ORAL AND MAXILLOFACIAL SURGERY

NAME_____ DATE _____

This patient has been referred to your office for the following:

____ Extraction ____ Implant Consult

____ Lesion Evaluation & Treatment ____ Orthodontic Exposure

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

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

Please list other procedures or any special remarks concerning this patient:

_____

_____

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_____

_____

_____
Referring Doctor

General Instructions:

1. Please be advised that certain cases require separate appointments for consultation and surgery.
2. Minors must be accompanied by a parent or legal guardian.
3. Please bring in a list of all of your medications
4. Please bring your dental & medical insurance cards.
5. Please notify the office at least 24 hours in advance to change or cancel an appointment.
6. Patients anticipating any sedation require a consultation prior to any treatment.

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