LAKES
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JEFFREY S. COHEN, D.D.S.

REFERRAL REQUEST

Patient name: _____ Date: _____

History: _____

_____

SERVICES REQUESTED:

__ Consultation
__ Infection
__ Apicoectomy
__ Alveoplasty
__ Biopsy
__ Extraction
__ Other _____

__ Impaction
__ Implant
__ Panorex X-ray
__ X-rays mailed
__ X-rays given to patient

__ Pre-Prosthetic Surgery
__ Surgical Exposure
__ Orthognathic Surgery
__ General Anesthesia
__ IV Sedation
__ Local Anesthesia

RIGHT LEFT

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

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

ADDITIONAL COMMENTS: _____

_____

_____

_____

Referred by Dr. _____ Phone: _____

APPOINTMENT REQUEST (please confirm or reschedule)

Date: _____ Time: _____

JEFFREY S. COHEN, D.D.S.

DIPLOMATE, AMERICAN BOARD OF
ORAL & MAXILLOFACIAL SURGERY

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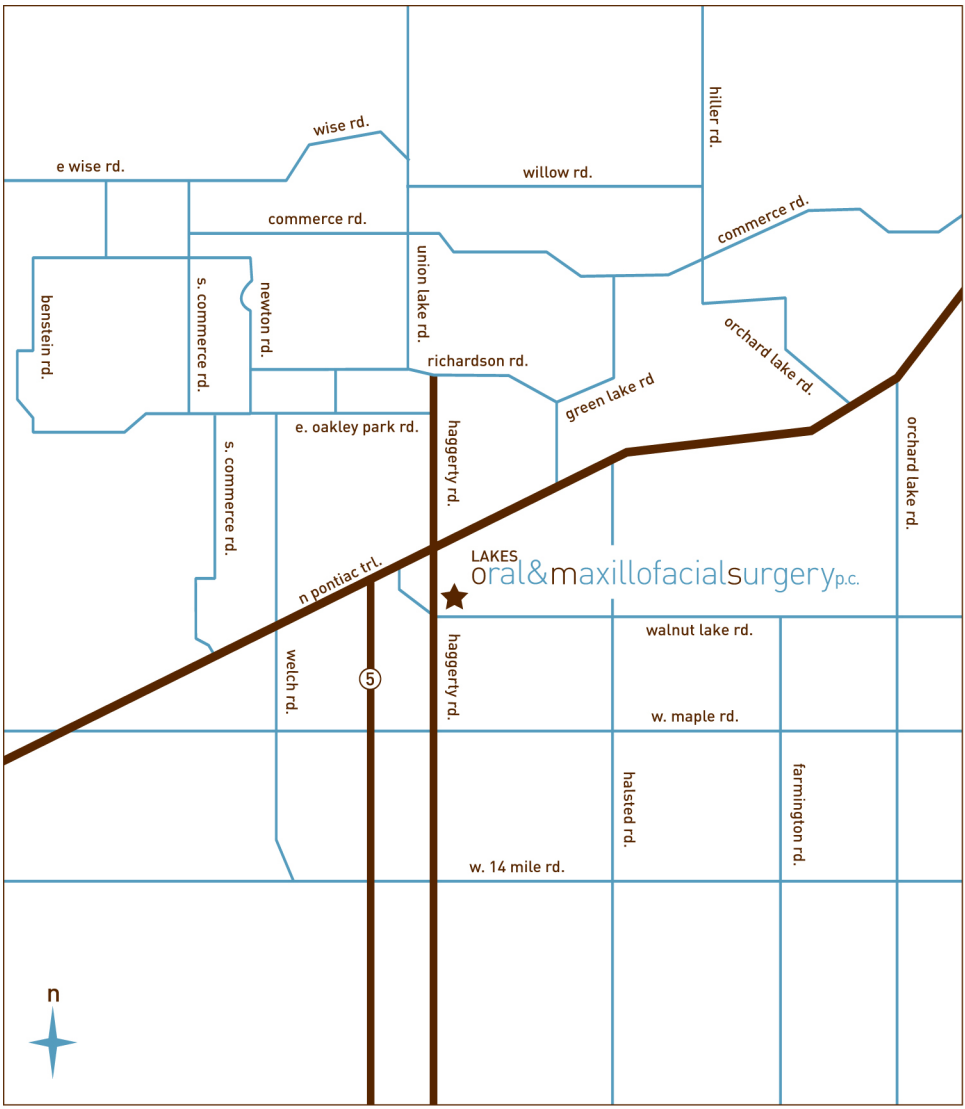

SPECIAL INSTRUCTIONS FOR IV SEDATION OR GENERAL ANESTHESIA:

Please have nothing to eat or drink at least 6 hours before surgery unless otherwise instructed.
Take any necessary medications with a sip of water only.

Must be accompanied and driven by a responsible adult.

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