

# LAKES oral & maxillofacial surgery p.c.

JEFFREY S. COHEN, D.D.S.      DEVONN E. ISRAIL, D.D.S.

## REFERRAL REQUEST

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

History: \_\_\_\_\_

## SERVICES REQUESTED:

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Impaction               | <input type="checkbox"/> Pre-Prosthetic Surgery |
| <input type="checkbox"/> Infection    | <input type="checkbox"/> Implant                 | <input type="checkbox"/> Surgical Exposure      |
| <input type="checkbox"/> Alveoplasty  | <input type="checkbox"/> Panorax X-ray           | <input type="checkbox"/> Orthognathic Surgery   |
| <input type="checkbox"/> Biopsy       | <input type="checkbox"/> X-rays mailed           | <input type="checkbox"/> IV Sedation            |
| <input type="checkbox"/> Extraction   | <input type="checkbox"/> X-rays given to patient | <input type="checkbox"/> Local Anesthesia       |
| <input type="checkbox"/> Other _____  |  |   |

## RIGHT

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

## LEFT

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: \_\_\_\_\_

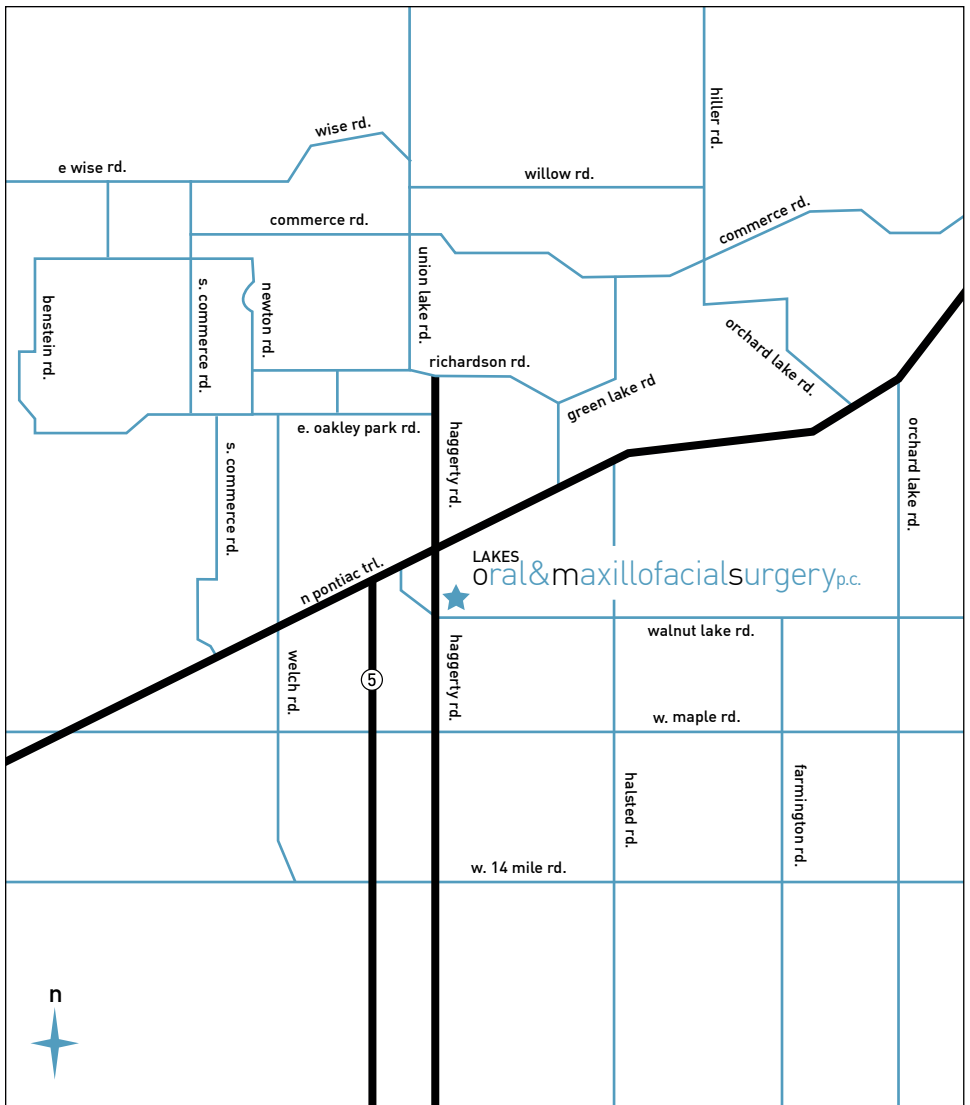
JEFFREY S. COHEN, D.D.S.

DEVONN E. ISRAIL, 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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