



Glen Burnie Ora Surgery Associates

Dental Implant Center

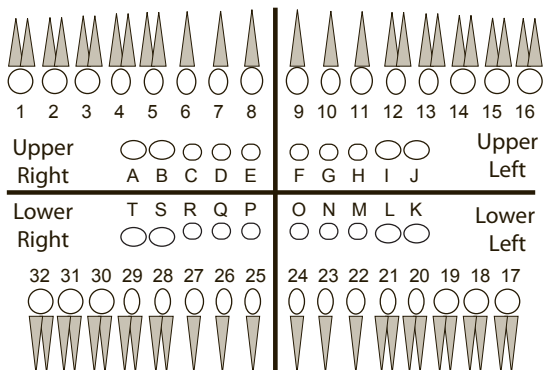
Allan V. Garfinkel , D.D.S • Saman Souri , D.M.D
300 Hospital Drive, Suite 237 • Glen Burnie , MD 21061
Tel: 410-761-4684 • glenburnieoralsurgery.com

Patient Name: _____

Referring Dr. _____ Appt. Date: _____

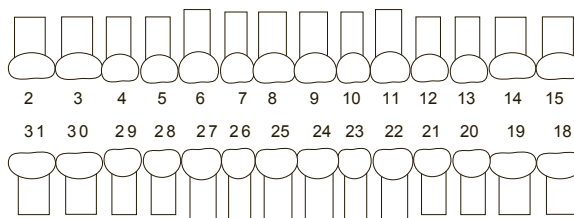
Procedure

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Extractions | <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> Exposure & Bond | <input type="checkbox"/> Torus Removal |
| <input type="checkbox"/> Bone Grafting | <input type="checkbox"/> 3D Cone Beam | <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Radiograph | <input type="checkbox"/> Sinus Augmentation | <input type="checkbox"/> Ridge Augmentation | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> TMJ | <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> IV Sedation |



Please mark proposed extraction site

Auxiliary procedures requested



Please shade proposed implant site

Preferred Implant

Surgical Template

- | | |
|--|--|
| <input type="checkbox"/> To be provided by restorative dentist | <input type="checkbox"/> To be fabricated by surgeon |
| <input type="checkbox"/> Other _____ | |

Radiographs

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Being mailed / E-mailed | <input type="checkbox"/> Hand carried by patient | <input type="checkbox"/> Please take |
|--|--|--------------------------------------|

**PLEASE NOTE THAT IN MOST INSTANCES THE PATIENT IS FIRST SEEN FOR CONSULTATION
TO REVIEW THE HEALTH HISTORY, DECIDE ON THE MOST APPROPRIATE ANESTHESIA AND TREATMENT
PLAN AND SCHEDULE THE SURGERY AT A SEPARATE APPOINTMENT**