HIGH DESERT
Oral & Facial Surgery

PATIENT INFORMATION

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **CONTACT TELEPHONE:** _____

DATE: _____

- ☐ FIRST AVAILABLE
- ☐ VERNON BURKE DMD, MD, FACS
- ☐ REO PUGAO DDS, MD, FACS
- ☐ HANS BROCKHOFF DDS, MD, FACS
- ☐ DAVID YATES DMD, MD, FACS
- ☐ NATASHA FÜRCHTGOTT DDS, MS

REFERRING DOCTOR'S INFORMATION

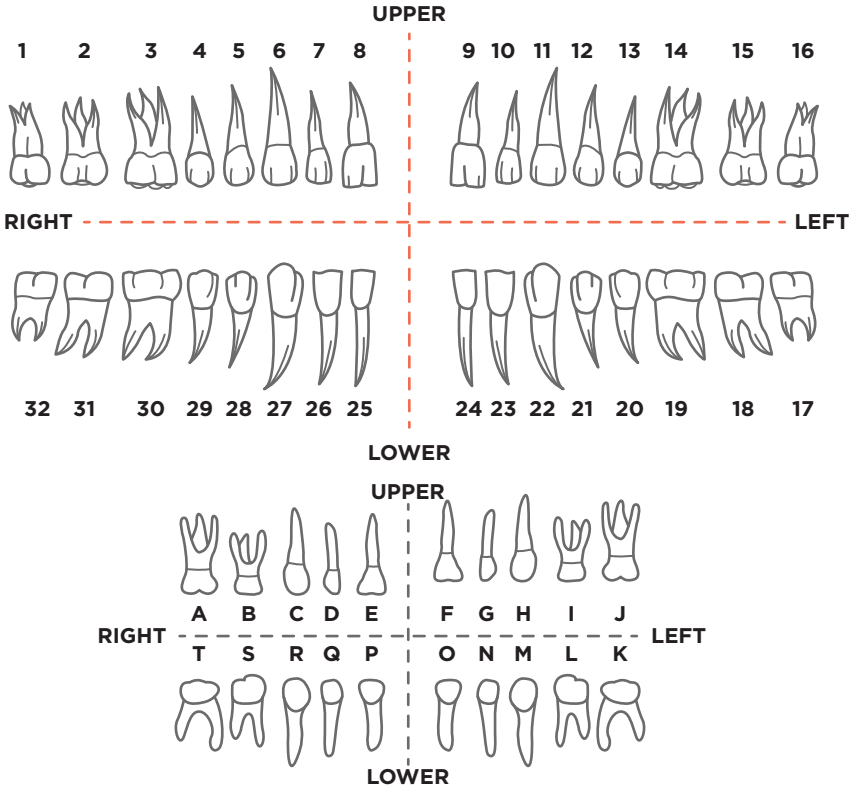
DOCTOR'S NAME: _____ **OFFICE NAME:** _____

OFFICE LOCATION: _____ **TELEPHONE:** _____
(If multiple sites)

PROCEDURES AND CONSULTATIONS

○ Alveoloplasty	○ Cleft Lip & Palate	○ Extraction (see below)	○ Orthognathic Evaluation	○ TMJ
○ Apicetomy	○ Cosmetic	○ Frenectomy	○ Pre-Prosthetic	○ **OTHER:**
○ Biopsy	○ Expose & Bond	○ Incision & Drainage	○ Ridge Augmentation	
○ Bone Grafting	○ Exposure	○ Oral / Facial Lesion	○ Soft Tissue	

IMPLANTS: **IMPLANT SYSTEM:**



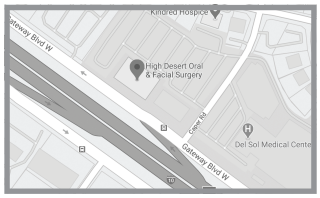
NOTES:

Please mark the teeth to be extracted in the diagram"

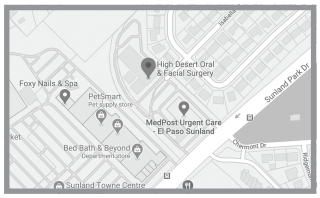
RADIOGRAPH OR CLINICAL PHOTOS

- ○ Being mailed
- ○ Given to patient
- ○ Please Take
- ○ No X-Ray

If X-Rays are attached, date in which they were taken:



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Fax (915) 599-8579



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