vancouveroralsurgery

Dr. Graham Grabowski
Certified Specialist in Oral & Maxillofacial Surgery

Date: _____ Patient Name: _____

Patient Cell: _____ Patient Email: _____

Patient Birth Date: ____ / ____ / _____ Patient Other Phone: _____
DD MM YYYY

Patient Insurance Info: _____

Referring Doctor: _____ Doctor Phone: _____

☐ Third Molars ☐ Dental Extraction(s) ☐ Bone Augmentation ☐ Tooth Exposure

☐ Pathology / Biopsy ☐ Orthodontic Implant ☐ Alveolar Cleft ☐ Facial Trauma

☐ Implant(s), Location: _____

☐ Sedation ☐ Other: _____

Teeth to be extracted:

			55	54	53	52	51	61	62	63	64	65				
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	
			85	84	83	82	81	71	72	73	74	75				

99 - Supernumerary: **Other:**

Radiographs: ☐ Mailed ☐ Emailed ☐ Enclosed ☐ With Patient ☐ Please obtain

Notes: _____

_____

_____

_____

Medical Alert: _____

Signature: _____

530 - 2425 Oak Street Vancouver, BC V6H 3S7
phone 604-736-0440 **fax** 604-736-4312 referral@oralsurgery.ca

oralsurgery.ca

vancouveroralsurgery

Dr. Graham Grabowski
Certified Specialist in Oral & Maxillofacial Surgery

Primary Dental Insurance

Name of Insured: _____

Relationship to patient: _____

Insured date of birth: _____

Insurance Company: _____

Group/Policy #: _____

Cert/ID #: _____

Division #: _____

Secondary Dental Insurance

Name of Insured: _____

Relationship to patient: _____

Insured date of birth: _____

Insurance Company: _____

Group/Policy #: _____

Cert/ID #: _____

Division #: _____

530 - 2425 Oak Street Vancouver, BC V6H 3S7
phone 604-736-0440 **fax** 604-736-4312 referral@oralsurgery.ca

oralsurgery.ca