

Oral & Maxillofacial Surgery

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Thomas Connolly, DMD ___ Paul Danielson, DMD ___ Richard Cordero, DMD, MD ___ James Freeman, DDS ___

Appointment Information: This time is reserved specifically for you. If by necessity, you must cancel your appointment, **please notify us at least two days in advance.** * **Please Note: An evaluation/ consultation visit is needed before surgery with general anesthesia can be scheduled.**

Appointment Date: _____ Time: _____

Patient's Name: _____ Date of Birth: ____/____/____

Patient's Telephone Number: _____ Work Number: _____

Referred By: _____ Date: _____

Copy to: _____

Special Instructions: _____

Please bring your medical and dental cards, as well as a photo I.D. to your appointment.

Please Circle Teeth to be Treated

| | | | | | | | | |
|--|--|-------------------------|-----------|--|-----------|-----------|--|-----------|
| Right | | Left | | | | | | |
| 01 02 03 04 05 06 07 08 | | 09 10 11 12 13 14 15 16 | | | | | | |
| 32 31 30 29 28 27 26 25 | | 24 23 22 21 20 19 18 17 | | | | | | |
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">A B C D E</td> <td style="border-left: 1px solid black; border-right: 1px solid black;"></td> <td style="text-align: center;">F G H I J</td> </tr> <tr> <td style="text-align: center;">T S R Q P</td> <td style="border-left: 1px solid black; border-right: 1px solid black;"></td> <td style="text-align: center;">O N M L K</td> </tr> </table> | | | A B C D E | | F G H I J | T S R Q P | | O N M L K |
| A B C D E | | F G H I J | | | | | | |
| T S R Q P | | O N M L K | | | | | | |

Evaluation

- Extraction (Circle Teeth Number)
- Implants
- Orthognathic
- TMJ

Other Procedures

- Apicoectomy
- Frenectomy
- Exposure
- Lesion Evaluation
- Infection
- Tori
- Other _____

Radiographs

- Enclosed
- Given To Patient
- Please Take
- Sent via email
to: referral@cvoms.com