

**Appointment Information:** This time is reserved specifically for you. If for any reason the appointment cannot be kept, kindly notify us two days in advance.

Date: 12/30/2025

Patient's Name: \_\_\_\_\_

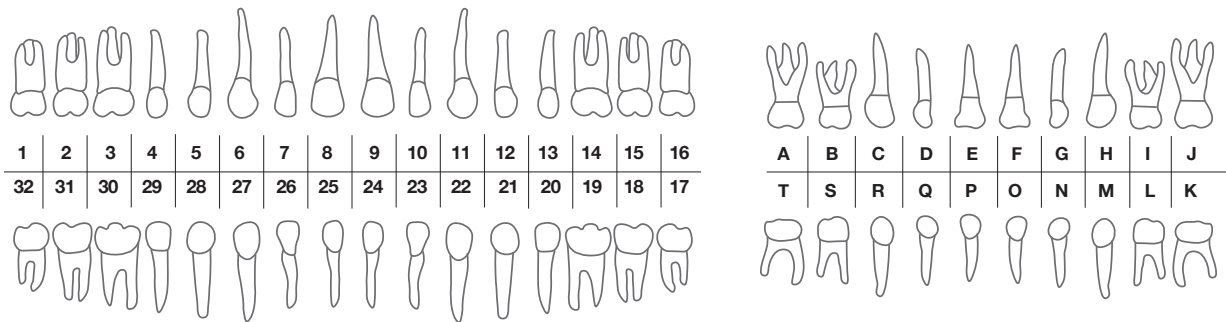
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

**Instructions to referred patients:**

1. This appointment is for a consultation. If your doctor is sending X-rays, please arrange for them to be here at the time of your appointment.
2. Go to our website to fill out your paperwork (bellaireoralsurgery.com).
3. Bring a list of all medications you are currently taking, including dosage.

**PLEASE MARK AREA TO BE TREATED**



- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Extraction    | <input type="checkbox"/> Alveoloplasty       | <input type="checkbox"/> Exposure   |
| <input type="checkbox"/> Biopsy        | <input type="checkbox"/> Frenectomy          | <input type="checkbox"/> Trauma     |
| <input type="checkbox"/> Expose & Bond | <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> Uprighting |

**CONSULTATION:**

- |  |  |
|--|--|
| <input type="checkbox"/> Dental Implants                       | <input type="checkbox"/> Orthognathic Evaluation |
| <input type="checkbox"/> Third Molar Removal                   | <input type="checkbox"/> Sleep Apnea             |
| <input type="checkbox"/> Complete Arch Restoration (All-on-4®) | <input type="checkbox"/> Cosmetic Facial Surgery |

**RADIOGRAPHS:**

- |                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Enclosed | <input type="checkbox"/> Given to Patient | <input type="checkbox"/> Please Take |
|-----------------------------------|---|--------------------------------------|

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