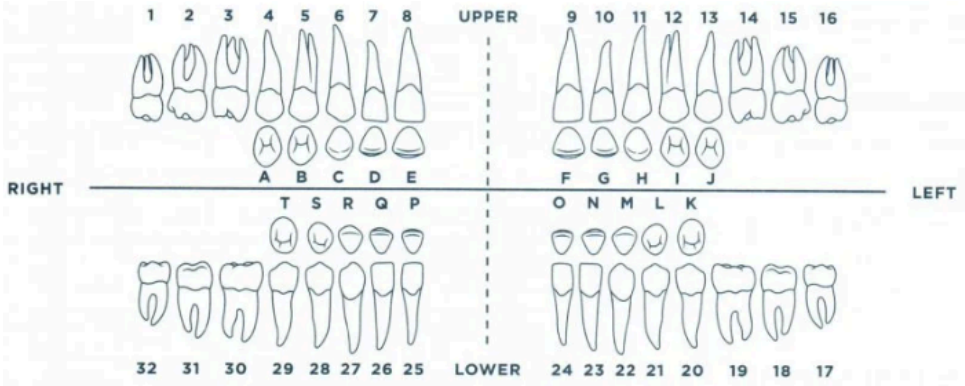


Patient's Name: _____ Date: _____

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> IV Sedation/General Anesthesia |
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Other: _____ |



List Teeth for Extraction: _____

Brief Medical History/Medical Considerations: _____

PCP/Specialist (MD): _____

X-Rays/Medical Records
(acquired within 12 months):

Panoramic X-Ray

Other Images

Emailed

Given to Patient

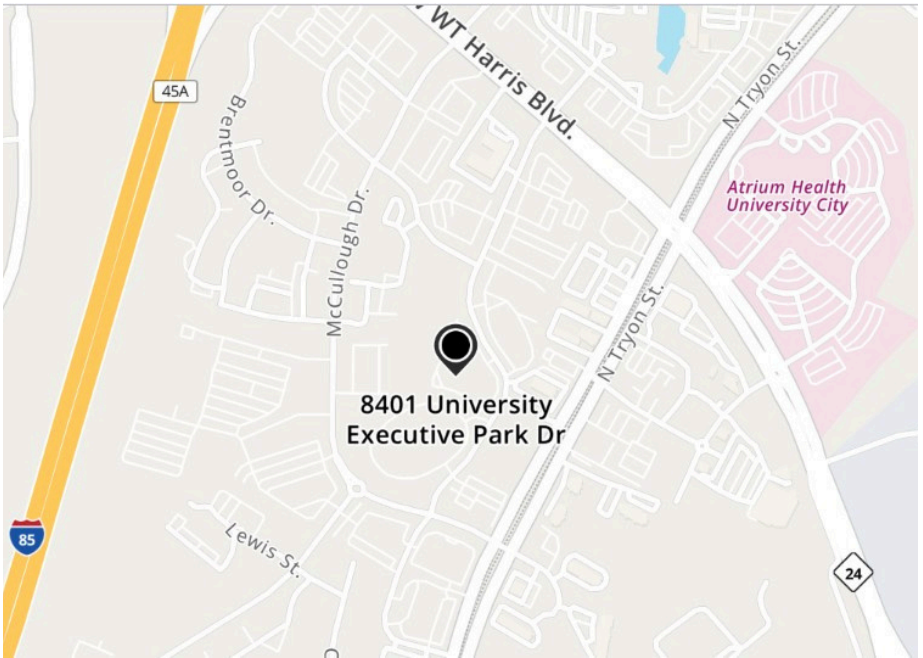
No X-rays

Please Email Current X-Rays/Medical Records to: MCC@oralsurgerycharlottenc.com

Referring Doctor (Name): _____

Referring Doctor Signature: _____

Appointment: _____ Time: _____



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Charlotte, NC 28262
704-412-0460

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www.oralsurgerycharlottenc.com

If you are scheduled for intravenous anesthetic, PLEASE DO NOT EAT or DRINK anything after midnight prior to your appointment. Any patient under the age of 18 years of age must be accompanied by a parent or guardian at the time of surgery.

Please have a responsible adult in the office with you during surgery and to drive you home after your visit.