Leon R. Peck, DDS, Ph.D.
Oral and Maxillofacial Surgery
8500 Wilshire Boulevard, Suite 815
Beverly Hills, CA 90211
Tel. (310) 657-6363 Fax (310)652-5785
drpeck@laoralsurgeon.com

ORAL SURGERY EVALUATION AND TREATMENT REQUEST

Patient Name ____ Date _______________

Appointment Date ______________________________ Time _____________________

Referred by Doctor ____

- ☐ Extractions (please mark the teeth to be extracted)
- ☐ Implants ____
- ☐ Pathology / Salivary Glands / Biopsy
- ☐ Maxillofacial Trauma
- ☐ Reconstructive / Preprosthetic Surgery
- ☐ TMJ / Orofacial Pain
- ☐ Apicoectomy, Tooth # ____
- ☐ Maxillofacial Infection
- ☐ Laser Treatment of Snoring
- ☐ Laser Treatment of Facial Skin Lesions

REMARKS ____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

RIGHT ____ LEFT

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

INSTRUCTIONS FOR PATIENTS RECEIVING GENERAL ANESTHESIA

1. **DO NOT EAT OR DRINK ANYTHING** for at least six hours before surgery.
2. Make arrangements to have someone drive you home following surgery.
3. Minors (under 18 years) must have parent or guardian present ai time of surgery.

PLEASE BRING THIS CARD WITH YOU