

**ORAL &
FACIAL
SURGERY
CENTERS OF
WASHINGTON**

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Puyallup, WA 98373

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Bryan Swanson, DDS

Specialists in Oral & Maxifacial Surgery
PHONE 253.445-0022 | FAX 253.445.0979
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Date: _____

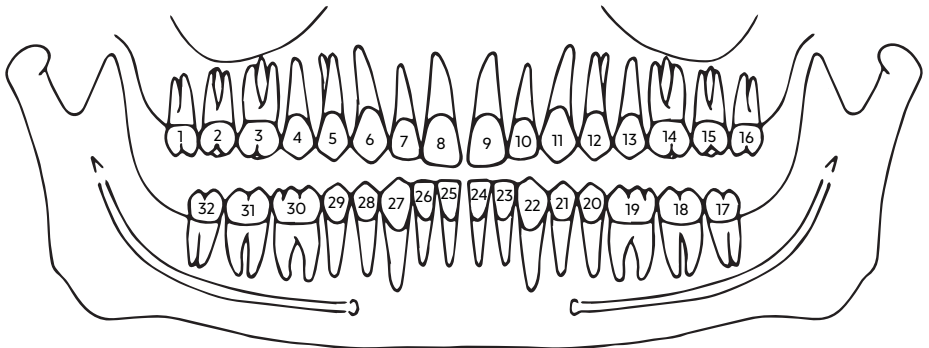
Introducing: _____ Daytime Phone: _____

Referred By: _____

Appointment Date: _____ Time: _____

- | | |
|--|---|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Other Treatment/Comments |
| <input type="checkbox"/> X-rays | |
| <input type="checkbox"/> As needed | _____ |
| <input type="checkbox"/> PA | _____ |
| <input type="checkbox"/> Panoramic | _____ |
| <input type="checkbox"/> Cone Beam CT | _____ |
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> Pathology | _____ |
| <input type="checkbox"/> Infection | _____ |
| <input type="checkbox"/> Implant consultation | _____ |
| <input type="checkbox"/> Orthognathic consultation | _____ |
| <input type="checkbox"/> Extraction | _____ |
| <input type="checkbox"/> Other _____ | _____ |

A	B	C	D	E		F	G	H	I	J
T	S	R	Q	P		O	N	M	L	K



RIGHT

LEFT

PATIENT INFORMATION

1. Please call 253.445.0022 to make an initial appointment.
2. An examination prior to surgery is necessary in most cases.
3. An accurate estimation of surgical fees can only be given after an examination.
4. If the patient desires IV anesthesia, he/she should be accompanied by a responsible adult and **must not eat or drink for 6 hours prior to the appointment.**
5. Minors should be accompanied by a parent or guardian.
6. Please bring recent radiographs of areas where surgery is to be performed, or have your dentist or physician send them **prior** to your examination appointment.
7. All fees are payable at the time of surgery unless other arrangements have been previously made.
8. Please bring current dental/medical insurance information.

