SOCALDSC™

WHITTIER DENTAL SPECIALISTS CENTER

Practice limited to ***Oral & Maxillofacial Surgery***

Apel Keuroghlian D.D.S. M.D.
Mark Wood D.D.S.
Ian Woo D.D.S. M.D.

7201 Painter Avenue
Whittier, CA 90602
Tel: 562-698-7925
Fax: 562-693-2217
Whittier@socaldsc.com

PLEASE BRING THIS CARD TO YOUR APPOINTMENT

Date: _____

Patient Name: _____

Appointment Date: _____ Time: _____ AM/PM

Referring Dentist: _____ **Office Phone Number:** _____

❑ Consultation Only ❑ Consultation and Treatment

Service Requested:

- ❑ Extraction
- ❑ Alveoplasty
- ❑ Frenectomy
- ❑ Expose & Bond
- ❑ Biopsy
- ❑ 3D Cone Beam CT
- ❑ Implant Consultation
- ❑ Call Prior to Consult/Tx
- ❑ IV Sedation
- ❑ Emergency

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

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

Comments: _____

_____

_____

_____

_____

Does patient require a Direct Referral or Authorozation Form from insurance provider?

❑ *Yes* ❑ *No*

Special instructions for patients receiving IV Sedation/ General Anesthesia will be given to patient upon treatment approval.

Final Report:

❑ **Mail** ❑ **E-Mail:** _____ ❑ **Fax:** _____

White Copy: ***Give to Patient***

Yellow Copy: ***Keep in office***