GREENWAY
SURGICAL

www.greenwaysurgical.com

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PATIENT INFORMATION

Name: ______________________ Guardian (if applicable): ______________________

Address: ______________________ Gender: ◯ Male ◯ Female

Phone: ______________________ Alt Phone: ______________________

Email: ______________________ Date of Birth: ______________________

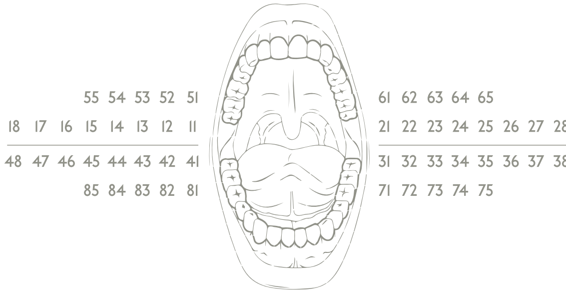
REFERRING DOCTOR

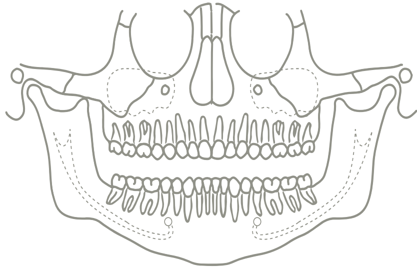
Name/Office: ______________________ Office Phone: ______________________

Date of Referral: __________ ◯ Please call patient to schedule ◯ Patient will call to schedule

Radiographs/Photos: ◯ Emailed ◯ Mailed ◯ Patient will bring ◯ Please take new ones

TREATMENT AREAS (please also indicate on diagram): ______________________





PROCEDURES OR CONSULTATIONS REQUESTED

◯ Extractions ◯ Dental Implants

◯ IV Sedation/GA ◯ Pathology/Biopsy

◯ Orthognathic Surgery ◯ Facial Cosmetics

◯ Trauma ◯ TMD/Facial Pain ◯ Exposure/Bond

◯ Preprosthetic ◯ OSA

Other: ______________________

DENTAL IMPLANTS

Implant Type: ◯ Straumann ◯ Nobel

◯ Digital Implant Impression Lab: ______________________

Would you like us to fabricate and insert a temporary prosthesis? ◯ Yes ◯ No

FULL ARCH

Patient is interested in:

◯ Fixed ◯ Removable ◯ Upper ◯ Lower

Prosthetic work is by:

◯ Referring Doctor ◯ Please Provide Referral

◯ Other Practitioner: ______________________

ADDITIONAL COMMENTS:

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