GREENWAY
SURGICAL

www.greenwaysurgical.com

Dr. Oxana Korj
Certified Specialist, Oral & Maxillofacial Surgery

Tel 778 655 9988 Fax 778 655 9995
6315 West Boulevard, Vancouver, BC V6M 0C1
info@greenwaysurgical.com

PATIENT INFORMATION

Name: _____ Guardian (if applicable): _____

Address: _____ Gender: ◯Male ◯Female

Phone: _____ Alt Phone: _____

Email: _____ Date of Birth: _____

REFERRING DOCTOR

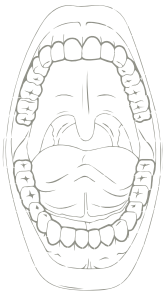
Name/Office: _____ Office Phone: _____

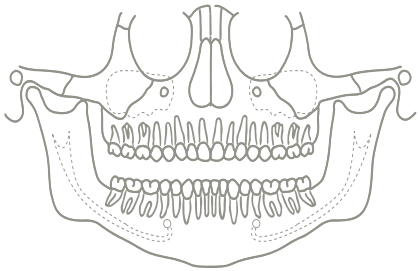
Date of Referral: _____ ◯Please call patient to schedule ◯Patient will call to schedule

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

TREATMENT AREAS (please also indicate on diagram): _____

				55	54	53	52	51	61	62	63	64	65			
18	17	16	15	14	13	12	11		21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41		31	32	33	34	35	36	37	38
				85	84	83	82	81	71	72	73	74	75			





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 ◯No Preference

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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