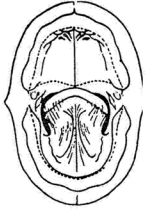
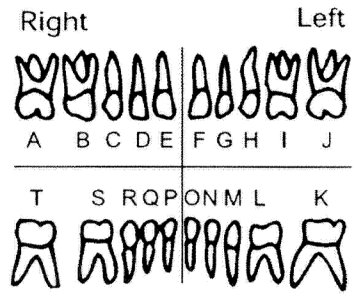
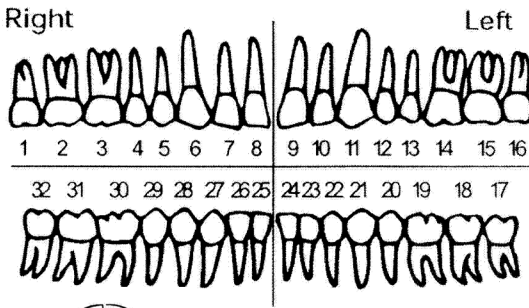




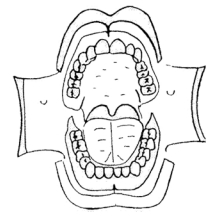
1707 61ST AVE, STE. 102
 GREELEY, CO 80634
 970-506-0350
 FAX: 970-506-0352
 WWW.BLEYORALSURGERY.COM

Introducing _____ Date of Birth _____ Phone _____

Referred by Dr. _____ Date _____



**PLEASE MARK TEETH
 TO BE TREATED**

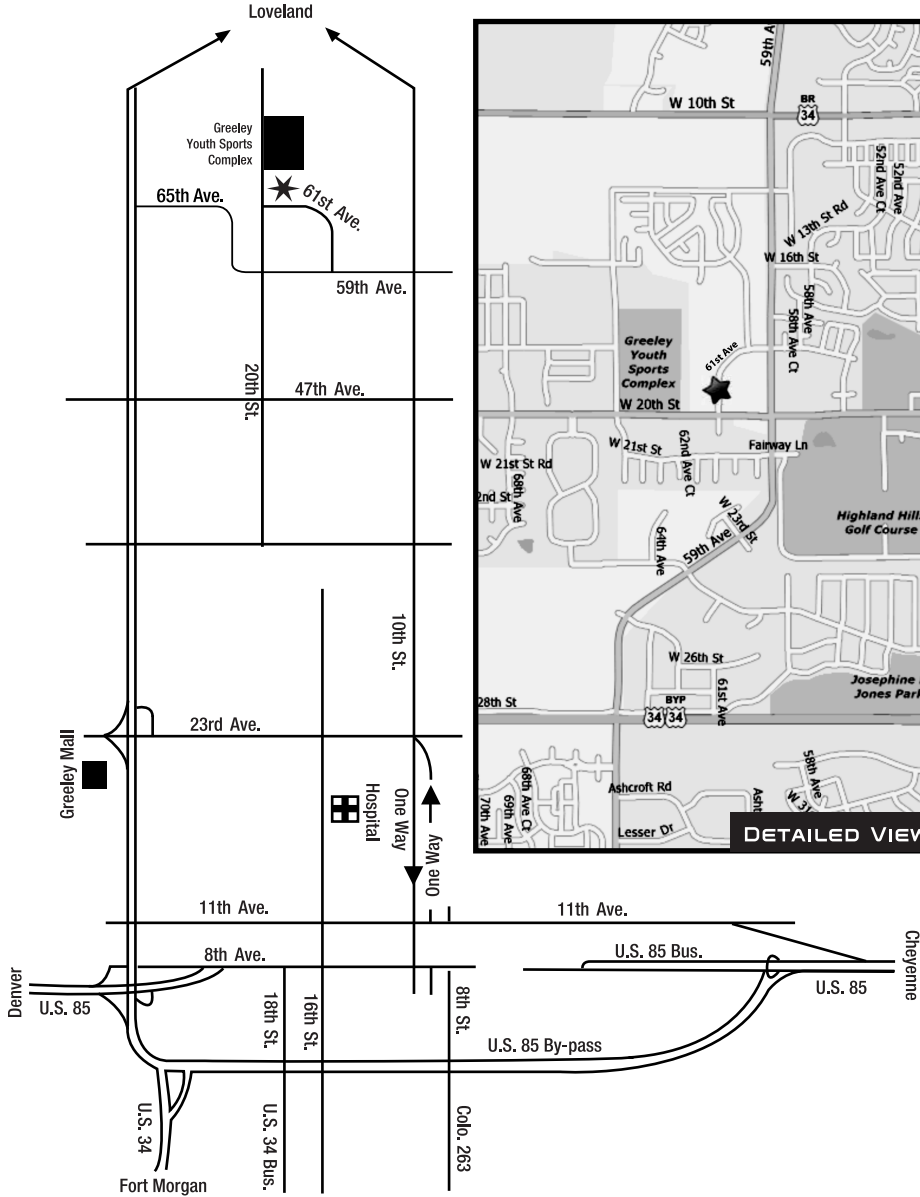


ALL SURGICAL patients should anticipate administration on **I.V. SEDATION** or **I.V. ANESTHESIA**. You **MUST** abstain from **ANY** and **ALL** food or liquid for **AT LEAST** six (6) hours prior to surgery and **MUST** be driven home. Failure to comply creates significant risks. Take **ALL** regular medications as usual unless specifically advised otherwise.

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Medical Status | <input type="checkbox"/> Implant |
| <input type="checkbox"/> Pre-Prosthetic | <input type="checkbox"/> Trauma | <input type="checkbox"/> Pathology |

RADIOGRAPHS: Take Sent With Patient
 Has Appt. _____ Will Call Call Patient

REMARKS: _____



J.C. BLEY, D.M.D.

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