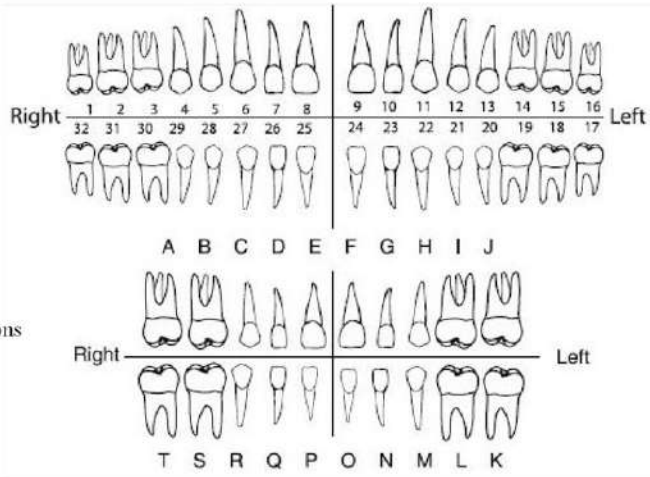
COSMETIC AND IMPLANT DENTISTRY of Kansas City



Patient Name: _____ DOB: _____

Guardian Name: _____ Phone: _____

Services Needed:

Treatment:

- ◯ Extractions
- ◯ IV Sedation
- ◯ Implants
- ◯ Bone Graft
- ◯ Tori Removal /Alveoloplasty
- ◯ Expose/Bond
- ◯ Infection/Pathology
- ◯ CBCT
- ◯ Implant Restorations
- ◯ Frenectomy
- ◯ Other

Comments: _____

_____

*Please note that IV sedation is only offered for oral surgery services.

Does the patient require antibiotic pre-medication? Yes ◯ No ◯

◯ Patient will call to schedule ◯ Please call patient to schedule.

Referring Doctor: _____

Phone: _____ Email: _____

PLEASE EMAIL REFERRAL AND X-RAYS

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