Spotsylvania Oral Surgery

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Patient Name: _____ **Phone:** _____

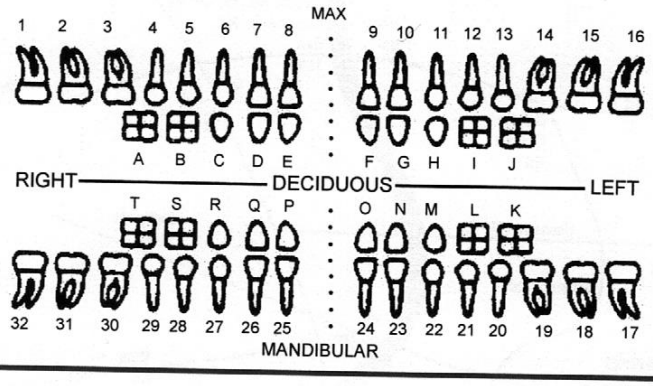
Referring by Dr. _____

Phone: _____ **Date:** _____

X-Rays Included: _____

Procedure to be Performed:

(X) FOR EXTRACTION (O) FOR X-RAY



Comments: _____

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IMPORTANT NOTICE

IF GENERAL ANESTHESIA OR INTRAVENOUSES SEDATION IS USED, THE PATIENT MUST HAVE **ABSOLUTELY NOTHING TO EAT OR DRINK FOR AT LEAST 6 HOURS BEFORE THE APPOINTMENT.** A RESPONSIBLE PERSON MUST ACCOMPANY YOU AND BE ABLE TO DRIVE YOU HOME, DO NOT PLAN TO DRIVE AN AUTOMOBILE THE DAY OF THE PROCEDURE. PLEASE WEAR COMFORTABLE CLOTHING TO THE OFFICE THE DAY OF YOUR SURGERY.

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