YELLICH & SALEHPOUR
ORAL SURGERY

George M Yellich, DDS, MS • Ali Salehpour MD, DDS
Board-Certified Oral & Maxillofacial Surgeons
950 Cass Street, Ste. B, Monterey, Ca., 93940
T: (831) 884-5141 F: (831)884-5176
info@yellichoms.com
www.YellichOralSurgery.com

PATIENT INFORMATION:

Today's Date_____Appointment Date _____Time _____❑ Patient will call for appointment ❑ Please call patient

First Name_____ Last Name_____ Date of Birth _____

Parent / Guardian Name_____

Contact Telephone _____Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No

Treatment_____

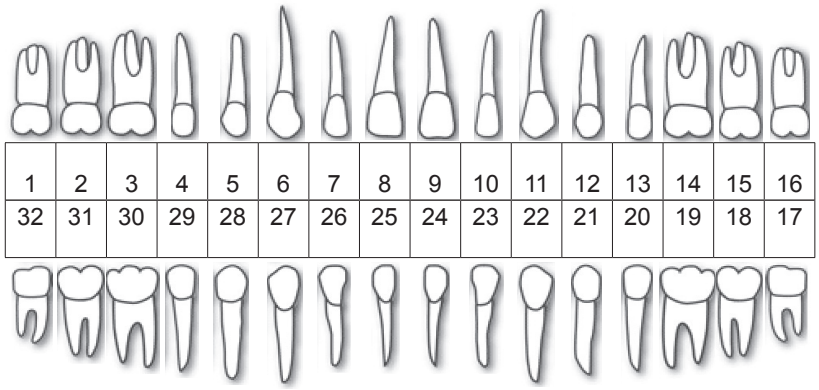
REFERRING DOCTOR'S INFORMATION:

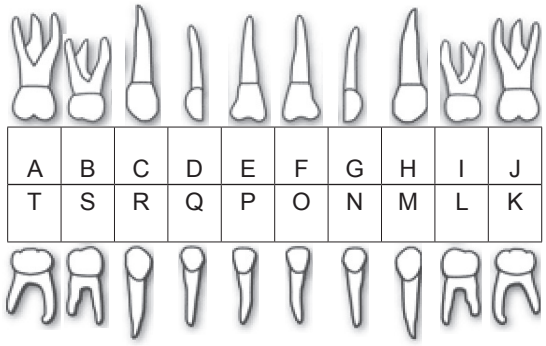
Referred By_____ Telephone _____

E-Mail Address_____

CONSULTATIONS & PROCEDURES:

❑ Wisdom Teeth
❑ Extraction(s) _____
❑ Implants _____
❑ Bone Graft
❑ Sinus Lift (circle side): UL or UR
❑ All-on-4 ® (circle arch): Maxilla or Mandible
❑ Expose & Bond
❑ Biopsy
❑ Alveoplasty (circle quadrants): UR UL LL LR
❑ Mandibular Tori
❑ Maxillary Tori
❑ Orthognathic Evaluation
❑ Incision & Drainage
❑ Lesion Evaluation
❑ Soft Tissue Grafting
❑ Frenectomy
❑ Other





Please Verify Teeth For Extraction_____

RADIOGRAPHS OR CLINICAL PHOTOS:

❑ Being Mailed
❑ Given To Patient
❑ Please Take: ❑ CBCT ❑ PANO ❑ PA
❑ No X–Ray
❑ Attached With This Referral; if X-Rays are attached, date taken_____

CASE NOTES: