



600 Corporate Drive  
Suite 260  
Ladera Ranch, CA 92694

(949) 799-4644  
 Fax (949) 449-2779

capistranooralsurgery.com  
 info@capistranooralsurgery.com

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Type: PPO HMO INDIV DISC INDEM EPO

Referring Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Radiographs:

DS Core  DTX  Emailed  Mailed  With Patient  Please Take

Please Evaluate and Treat:

\_\_\_\_\_ Extractions

\_\_\_\_\_ Bone Grafting

1 2 3 4 5 6 7 8

A B C D E

Upper

\_\_\_\_\_ Implants

\_\_\_\_\_ Biopsy

9 10 11 12 13 14 15 16

F G H I J

\_\_\_\_\_ Orthognathic

\_\_\_\_\_ Facial Cosmetic

Right

Left

Other: \_\_\_\_\_

32 31 30 29 28 27 26 25 T S R Q P

24 23 22 21 20 19 18 17 O N M L K

Lower

Surgical Instructions:

If you are scheduled for surgery, NO FOOD or LIQUID for 8 hours before your appointment. DO NOT plan to drive home. Please wear flat shoes and short sleeves. If you are a MINOR (Under 18 years) you must be accompanied by a parent or legal guardian.

Remarks: \_\_\_\_\_

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