



IMPLANTS AND ORAL SURGERY, PC.
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707 Paluxy Road
 Granbury, TX 76048
 817-573-1855 Fax: 817-573-4985

Referring Dr.'s Name: _____ Date: _____

Patient Name: _____

History: _____

SERVICES REQUESTED:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Impaction | <input type="checkbox"/> X-rays emailed |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Implant | <input type="checkbox"/> Referral letter emailed |
| <input type="checkbox"/> Apicoectomy | <input type="checkbox"/> Panorex X-ray | <input type="checkbox"/> Pre-Prosthetic Surg. |
| <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> X-rays mailed | <input type="checkbox"/> Surgical exposure |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> X-rays given to patient | <input type="checkbox"/> Orthognathic Surg. |
| <input type="checkbox"/> Extraction | | |
| <input type="checkbox"/> Other _____ | | |

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Right								Left							
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
T	S	R	Q	P	O	N	M	L	K	J	I	H	G	F	E

Additional Comments: _____

Welcome to our Oral and Maxillofacial Surgical Office.

Our office is committed to providing you with the highest quality of care. To help us in scheduling your appointment, please remember the following.

- The initial visit, with the exception of certain emergency cases, is for consultation only. This enables us to fully evaluate your problems and tailor the care to your specific needs.
- Unmarried patients under eighteen (18) years of age must be accompanied by a parent or legal guardian at the time of the initial consultation.
- Please bring all pertinent medical information, including a list of all doctors names with phone number and medications you arc currently taking.
- If you have medical or dental insurance, please bring the completed forms.
- If your dentist has taken X-rays you may request they forward to our office.

Signed: _____ Date: _____

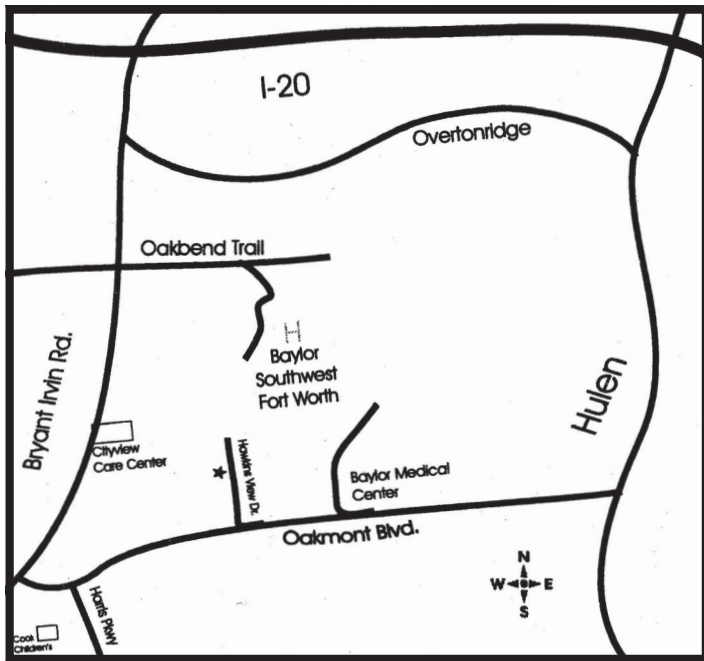
Referring Doctor

Referring Dr.'s Name: _____

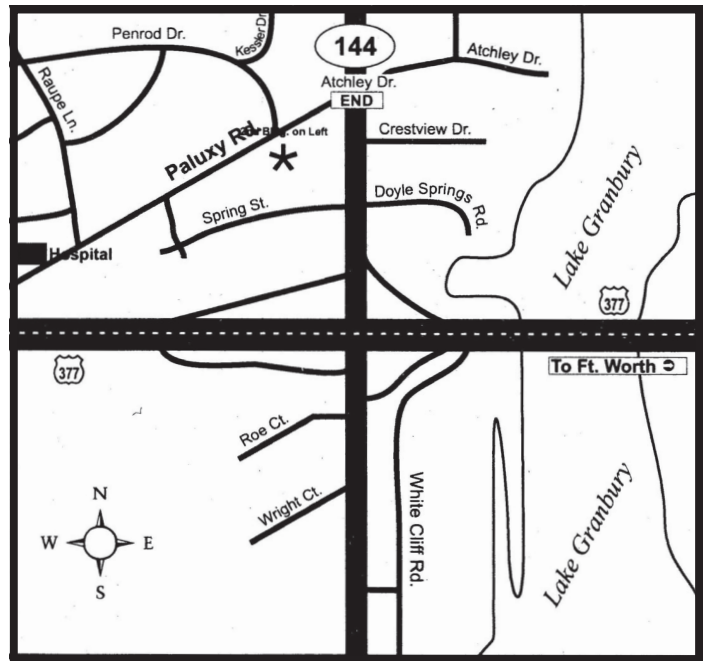
APPOINTMENT REQUEST (Please confirm or reschedule)

Date _____ Time: _____

Patient Referred to Dr.: _____



FORT WORTH OFFICE
 7217 Hawkins View Drive, Ste. 200
 Fort Worth, Texas 76132



GRANBURY OFFICE
 707 Paluxy Road
 Granbury, TX 76048

* Please refer to our website for information about our practice.

www.ftwosa.com