



OLYMPIA ORAL AND MAXILLO-FACIAL SURGERY

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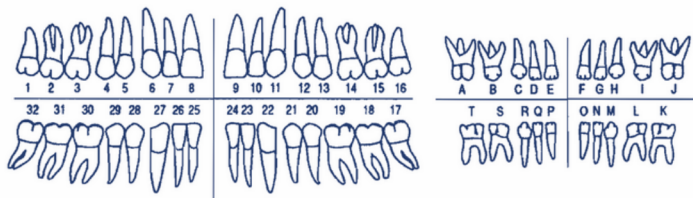
**(360) 923-5412
Fax (360) 923-5382**

Patient's Name _____ Date _____

Patient's Telephone # (_____) _____

Referring Doctor _____

PLEASE EXTRACT TEETH AS MARKED (X)



OTHER SURGERY INSTRUCTIONS:

- BIOPSY AREA _____
- IMPLANTS _____
- ORTHOGNATHIC SURGERY OTHER _____

REMARKS: _____

PLEASE SEND MORE REFERRAL FORMS

(PLEASE SEE MAP AND PATIENT INSTRUCTIONS ON BACK)