



D E E R

DENTAL SPECIALISTS

ORAL & MAXILLOFACIAL SURGERY

10 Phillip Road, Suite 117, Vernon Hills, IL 60061, 847-918-1900

www.deerpathdental.com

Referring Doctor _____ Appointment Date _____

Patient's Name _____

INSTRUCTIONS FOR PATIENTS

1. Please bring this referral slip with you.
2. If you are unable to keep your appointment for any reason, please notify the office promptly.
3. If you are to have a general anesthetic, do not eat or drink for at least six hours before your appointment.
4. You may not drive after receiving a sedative or a general anesthetic. Please make arrangements to be taken home.
5. If you have had rheumatic fever, diabetes, heart or vascular surgery, or if you take anticoagulants, please contact us before the day of your appointment for special instructions.
6. Please use the lavatory before your appointment.
7. Wear loose fitting clothing.
8. The financial obligation for the treatment we provide is your responsibility. We ask that fees be paid at the time services are rendered.
9. Payments can be made by cash, check or bank charge.
10. Please bring insurance forms at the time of surgery.
11. If you have any questions, please feel free to call us or make an appointment for consultation.

UPPER

					A B C D E F G H I J															
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					
					T S R Q P O N M L K															

LOWER

GENERAL ANESTHESIA LOCAL ANESTHESIA

SPECIAL INSTRUCTIONS OR COMMENTS _____

SIGNATURE OF REFERRING DOCTOR _____

DATE _____

X-RAYS MAILED

X-RAYS GIVEN TO PATIENT

PLEASE TAKE X-RAYS