



*Committed to
Professional and Friendly Care*

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- Oral and Maxillofacial Surgery
- Dental Implants

Date: _____ Daytime Phone: _____

Patient: _____ Date of Birth: _____

Address: _____

Appointment: Rockford Grand Rapids Patient Will Schedule Appointment
Date _____ Time: _____

X-Rays:
 Attached Emailed Mailed Separately Given to Patient Not Available

Recommended Treatment:

- | | |
|--|---|
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Edentulous Ridge Augmentation |
| <input type="checkbox"/> Bone Preservation Graft | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Orthodontic Exposure | <input type="checkbox"/> Evaluate T.M.J. Dysfunction |
| <input type="checkbox"/> Frenectomy | <input type="checkbox"/> Endosseous Implant |
| <input type="checkbox"/> Biopsy Lesion | <input type="checkbox"/> Examination, Consultation Regarding: |
| <input type="checkbox"/> Vestibuloplasty/Alveoloplasty | _____ |

Right			A	B	C	D	E	F	G	H	I	J	Left		
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			

Insurance: Insurance information completed. (See back of third copy)

Significant Health History: _____

Special Considerations: _____

Referring Doctor's Signature: _____

Anesthesia: *If the patient prefers intravenous (I.V.) anesthesia, they must be accompanied by a responsible adult and they must not eat or drink anything except for prescribed medication for six hours before the appointment.*

Minors: *Must be accompanied by a parent or legal guardian.*

Fees: It has been requested that the patient make a partial payment of \$ _____ on the day of treatment. Total fee estimates are possible if suitable x-rays are received in advance. Please telephone our office for more information.

Top Copy: Patient

Second Copy: Your Chart

Third Copy: Please Mail

Please send referral slips.

Insurance Information

Insurance Company _____

Phone and Address _____

Insured _____

DOB _____

SOC # _____

Employer _____ Group # _____

Secondary Insurance _____

Insurance Company _____

Phone and Address _____

Insured _____

DOB _____

SOC # _____

Employer _____ Group # _____

Medical Insurance _____

Phone and Address _____
