



Grant M. Hogan, DDS, MD
 DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY
 2250 Satellite Boulevard, Suite 150 · Duluth, GA 30097-4075
 Office: 770.232.1191 · Fax: 770.232.2733
 www.gafacial.com

Referral Date: _____
 Introducing: _____
 Referring Doctor: _____
 Drs. Telephone: _____

Implant Evaluation: _____

Please Evaluate For The Following:

Removal of teeth (marked below)

	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				
Right								Left											
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							

Pathology: _____

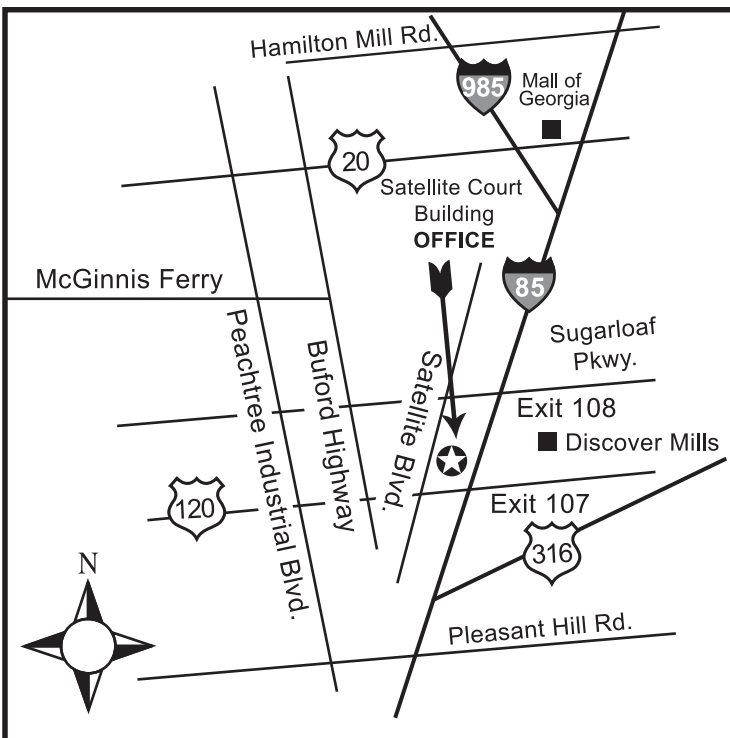
Sleep Apnea Surgery Evaluation

Orthognathic Surgery Evaluation

Remarks or Special Instructions

Expose & Bond (marked above)

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Instructions to Patients

You have been referred to our office for specialized treatment by an Oral & Maxillofacial Surgeon. We provide care in a comfortable environment. Please have the following available at your appointment to assist us in providing you excellent service:

- This surgical referral slip and any x-rays if applicable,
- A list of the medications that you are presently taking,
- If you have medical or dental insurance, please bring the necessary card/forms, as this will allow us to help you process any claims.

IMPORTANT: Patients under the age of 18 years must be accompanied by a parent or guardian at the first visit.

- Your first appointment is usually for a consultation and evaluation only. Any surgery that may be necessary will be discussed in detail with you at that time. The date for surgery will then be scheduled through our office.
- Please alert our office if you have a medical condition that may be of concern prior to surgery (i.e., diabetes, high blood pressure, artificial heart valves & joints, rheumatic fever).
- Please call us for any concerns or questions you have.