Ocoee Oral Surgery **Hunter T. McCord, DDS** **Paul T. McCord, DDS**

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Surgery Referral

Patient name: _____Phone number: _____

Parent's name (if minor): _____

Referring Dentist: _____ Patient date of birth: _____

Treatment requested: _____

Replacement plan, if any_____

Patient is _____ years of age

Insurance: _____/copy of card_____

_____ panoramic x-ray, taken within 90 days

MEDICAL HISTORY Y or N

_____ allergies

_____ respiratory/asthma/COPD

_____ taking blood thinners

_____ heart or stroke issues, including heart attack, stent placement, developmental defects, A-fib etc.

_____ diabetic

_____ meds for bones/osteoporosis/ bisphosphonates/Fosamax

_____other significant medical history, please list:

_____

_____

MEDICATIONS FOR THIS ISSUE

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