ALL ALASKA
ORAL & CRANIOFACIAL SURGERY

Dr. Jason E. Dashow, DDS, MD

4200 Lake Otis Parkway, Suite 202
Anchorage AK 99508
(907) 764-4760
(907) 764-4762
info@AllAlaskaOralCraniofacialSurgery.com
www.AllAlaskaOralCraniofacialSurgery.com

Evaluation and Treatment Request

Patient's Name: _____ Date of Birth: _____

Today's Date: _____ Patient's Phone: _____

Right **Left**

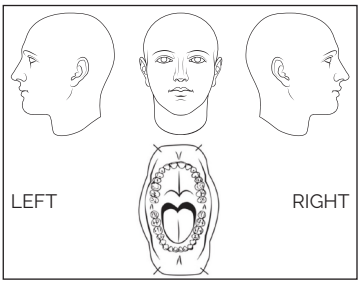
			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	L			

Procedures:

- ☐ Extraction(s) Tooth# ____
- ☐ Socket preservation
- ☐ Wisdom teeth
- ☐ Dental implant(s) Tooth# ____
- ☐ Bone graft
- ☐ Expose Tooth# ____
- ☐ Expose & Bond Tooth# ____
- ☐ Apicoectomy Tooth# ____
- ☐ Alveoloplasty
- ☐ Tori removal
- ☐ Pre-prosthetic
- ☐ Biopsy (Soft tissue/Hard tissue)
- ☐ Incision & drainage
- ☐ Frenectomy
- ☐ Sinus lift
- ☐ Supernumerary Extraction Tooth# ____
- ☐ Other

Consultations:

- ☐ Dental Implant(s) Tooth# ____
  - ☐ Screw-retained
  - ☐ Cemented
  - ☐ Implant Bridge
  - ☐ Implant-Retained Overdenture
  - ☐ Hybrid
  - ☐ Ceramic Implant
- ☐ CBCT
- ☐ Orthognathic
- ☐ Distraction Osteogenesis
- ☐ Craniofacial condition
- ☐ Cleft lip & palate
- ☐ TMJ
- ☐ Cosmetic
- ☐ Trauma
- ☐ Oral/cranio/facial lesion
- ☐ Infection
- ☐ Obstructive Sleep Apnea
- ☐ Other



Additional Comments

Please read this important information before your appointment.

- Your first appointment is usually a consultation to determine your specific treatment needs. Treatment may or may not be performed the same day as your consultation.
- If you would like to be sedated, DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE SURGERY. Also, you must be accompanied by an adult, who will drive you home and stay with you for a few hours following surgery.
- Please bring all medical and dental insurance information with you.
- Please bring a list of your medications, supplements, doses, and frequency of each.
- A parent or legal guardian must accompany patients under 18 years of age.
- Please give 48-hour notice to change or cancel appointments as a courtesy to other patients.
- Please bring X-rays (if provided) and this referral slip with you to your appointment.

Referring Provider _____

Practice Name & Phone _____

Provider Signature _____

Radiography

- ☐ X-ray given to patient
- ☐ X-ray mailed
- ☐ X-ray emailed
- ☐ X-ray needed (none sent)
- ☐ Please return X-rays.