

BAY CENTER for JAW SURGERY

DR. JAMES L. HORNER DR. GLEN E. JONES
DR. JESSE M. JAKUBOWSKI
 ORAL AND MAXILLOFACIAL SURGERY

DATE _____
 TIME _____
 LOCATION _____

PLEASE PRINT

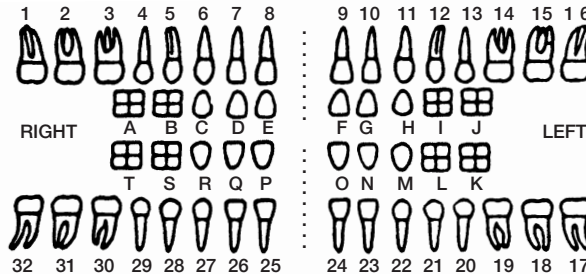
168 - 14th St. S.W.
 Suite B
 Largo, FL 33770
 (727) 585-5494

6700 Crosswinds Dr. N.
 Suite 100-B
 St. Petersburg, FL 33710
 (727) 821-5375

4338 - 1st St. N.
 Suite C
 St. Petersburg, FL 33703
 (727) 822-2228

RE: _____ DATE _____

1. PANORAMIC X-RAY ONLY
 2. DIAGNOSTIC CONSULTATION INCLUDING PANORAMIC X-RAY
 3. FOR EXTRACTION (X) FOR CROWN EXPOSURE (O)

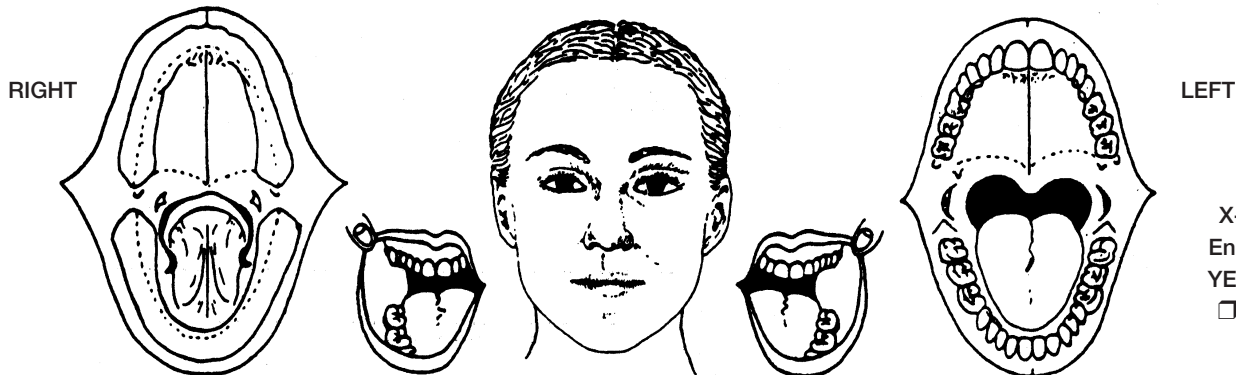


X-Rays Enclosed
 YES NO

Please write a brief description of the procedure: _____

4. BIOPSY THE FOLLOWING TISSUE: (Color, size, and location)

Tentative Diagnosis: _____



X-Rays Enclosed
 YES NO

5. OTHER SURGICAL PROCEDURES:

- Procedure
- Alveoplasty
 - Removal of Tori and/or Torus
 - Apicoectomy
 - Frenectomy
 - Other _____

Location

Please write a brief description of the procedure: _____ X-Rays Enclosed
 YES NO

RECOMMENDED ANESTHESIA: (If specifically requested)

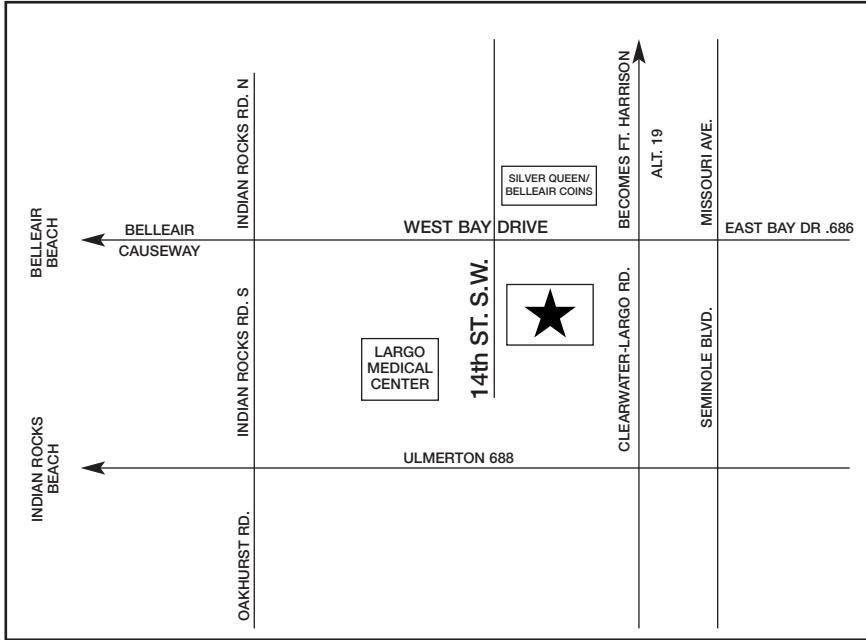
- Local
- I.V. Sedation
- General (Please advise our appointment secretary so the patient can be instructed not to eat or drink anything from midnight the night before his/her appointment and to be accompanied by an adult who can drive).

REFERRING DOCTOR: _____ NAME _____ PHONE _____

NOTE: Minors should be accompanied by their parent or legal guardian.
 A note will be sent from our office when the procedure you requested has been completed,
 and all x-rays sent to our office will be returned. We appreciate your confidence.

FOR OFFICE USE ONLY
 Procedure report sent to referring Doctor.
 X-Rays Returned.

YELLOW COPY FOR YOUR RECORDS

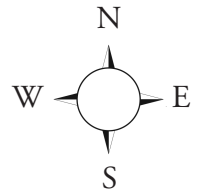
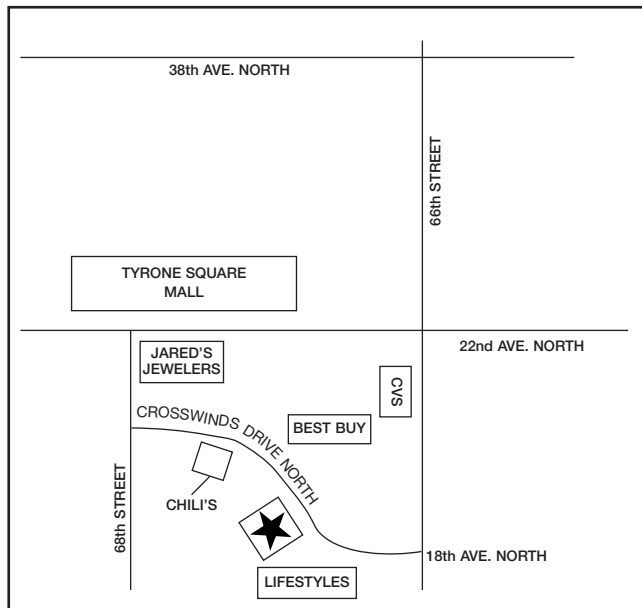


LARGO OFFICE

168 14th St. S.W.
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(727) 585-5494

TYRONE OFFICE

6700 Crosswinds Dr. N.
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NORTHEAST OFFICE

4338 1st St. N.
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