

PLEASE PRINT

BAY CENTER FOR ORAL & IMPLANT SURGERY

DR. GLEN E. JONES DR. JESSE M. JAKUBOWSKI

DR. CHRISTOPHER P. MALY

ORAL AND MAXILLOFACIAL SURGERY

DATE _____

TIME _____

LOCATION _____

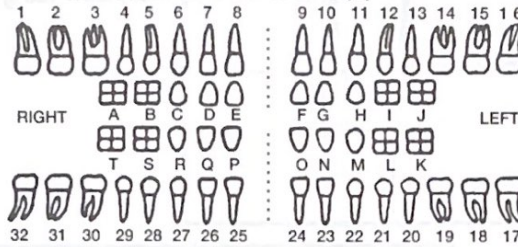
168 - 14th St. S.W., Suite B
Largo, FL 33770
(727) 585-5494 • Fax: (727) 584-1820
largo@baycenter.com

6700 Crosswinds Dr. N., Suite 100-B
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4338 - 1st St. N., Suite C
St. Petersburg, FL 33703
(727) 822-2228 • Fax: (727) 822-2441
ne@baycenter.com

RE: _____ DATE _____

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

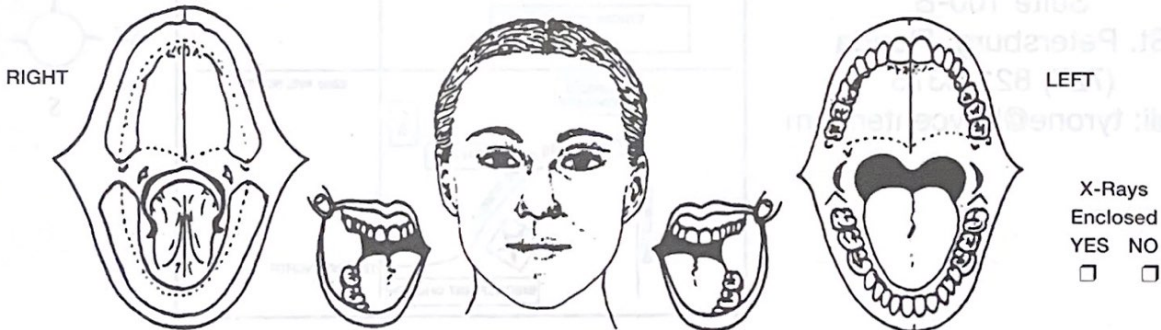


X-Rays Enclosed
YES NO

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:

- 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)

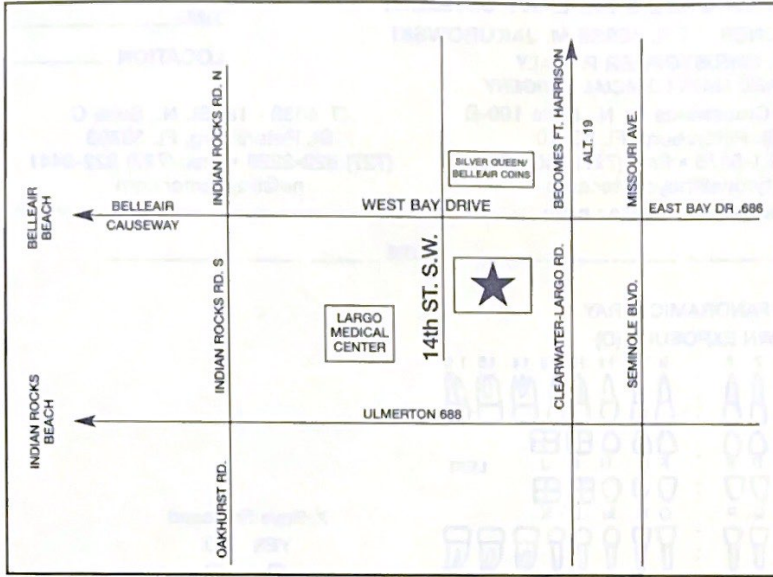
- Local
- I.V. Sedation
- General (Please advise our appointment secretary so the patient can be instructed not to eat or drink anything from midnight the night before his/her appointment and to be accompanied by an adult who can drive).

REFERRING DOCTOR: _____ NAME _____ PHONE _____

NOTE: Minors must be accompanied by their parent or legal guardian.
If you have recent x-rays of the surgical area, please bring them with you.
A panorex may be required by our office. We appreciate your confidence.

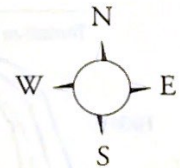
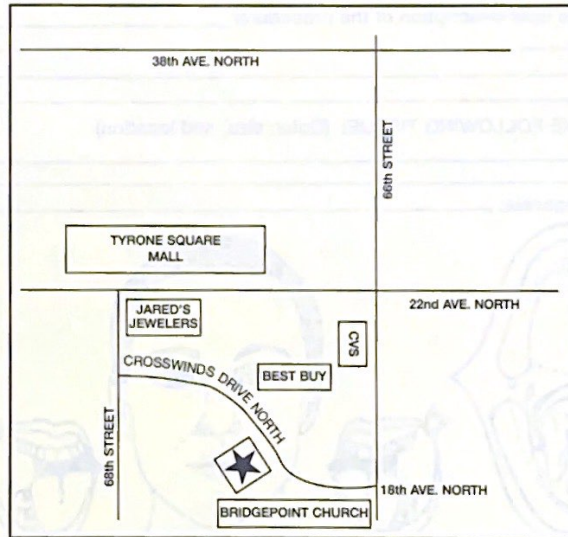
FOR OFFICE USE ONLY	
<input type="checkbox"/>	Procedure report sent to referring Doctor.
<input type="checkbox"/>	X-Rays Returned.

YELLOW COPY FOR YOUR RECORDS



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