Toronto East Maxillofacial Surgery

DR. ADAM KAPLAN
DR. REN CHANG
DR. HAISSAM KANAAN
Oral and Maxillofacial Surgeons

Referring Dr.:_____Date: _____

Referring Dr. Phone & Email:_____

Patient: _____
First Name Last Name

Mobile: _____ Work Phone: _____ Email:_____

Appointment Date:_____Time: _____

- ❒ Extraction
- ❒ Implant
- ❒ Bone Grafting
- ❒ Sinus Lift
- ❒ Pathology
- ❒ Infection
- ❒ Sleep Apnea
- ❒ Exposure of Impacted teeth
- ❒ Orthognathic Surgery
- ❒ Temporary Anchorage Device
- ❒ Temporomandibular Joint Disorders
- ❒ Pediatric Treatment
- ❒ Trauma
- ❒ Other

Please Check Teeth Or Areas To Be Evaluated:

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	E D C B A	A B C D E
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	E D C B A	A B C D E

Remarks Or Special Instructions: _____

_____

_____

_____

_____

_____

Radiographs: ❒ Being Mailed ❒ Given To Patient ❒ Please Take

❒ Send Copies Of Radiographs ❒ Emailed To admin@temfs.com

1490 Danforth Avenue, Suite 201, Toronto, ON M4J 1N4
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IMPORTANT INFORMATION TO READ

- If rescheduling your appointment is necessary, 48 hours notice is required or a fee will be charged for the time reserved.
- If you require sedation, have no food or drink for eight hours prior to your appointment and arrange to have someone accompany you home.
- Minors must be accompanied by a parent or legal guardian.
- Bring this form with you for your appointment.
- Payment for your treatment is required at the time of your appointment via Visa, Mastercard, debit or cash.
- Please wear clothing with short sleeves.
- For patients wearing contact lenses, please bring your carrying case.

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