DR. WENDALL MASCARENHAS *DDS, MD, FRCD(C), Dip. ABOMS*
DR. JOHNSON CHEUNG *DDS, MD, MSc, FRCD(C)*
Oral and Maxillofacial Surgeons

111 Queen St West, Suite 202 | Brampton, ON L6Y 2E4 | www.fcos.ca
phone (905) 457-8676 | **fax** (905) 457-3735 | **email** info@fcos.ca

FOUR CORNERS ORAL SURGERY

DATE DD_____ / MM _____ / YYYY_____

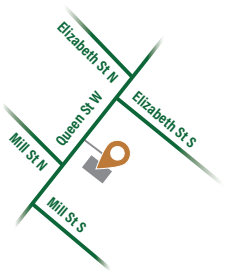
PATIENT'S NAME _____ **AGE** _____

PATIENT'S PHONE (_____) _____

PATIENT'S EMAIL _____

REFERRING DOCTOR _____

OFFICE PHONE (_____) _____



PERMANENT

R	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	L
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

PRIMARY

R	55	54	53	52	51	61	62	63	64	65	L
	85	84	83	82	81	71	72	73	74	75	

REASON FOR REFERRAL

- ❑ Extraction(s)
- ❑ Infection Treatment
- ❑ Bone Graft
- ❑ Trauma
- ❑ TMJ Surgery*
- ❑ Third Molar Extraction(s)
- ❑ Implant Placement(s)
- ❑ Biopsy of Lesion
- ❑ Expose & Bond
- ❑ Orthognathic Surgery
- ❑ Other _____

**PDF form to be completed by patient; on website*

COMMENTS _____

RADIOGRAPHS

- ❑ X-Rays have been emailed to **info@fcos.ca**
- ❑ X-Rays have not been taken
- ❑ X-Rays were given to the patient

APPOINTMENT

- ❑ Please arrange appointment
- ❑ Patient will arrange appointment

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT