SOCALDSC™

THE VIEW DENTAL SPECIALTY CENTER

Practice limited to ***Oral & Maxillofacial Surgery***

1245 W. Huntington Dr.
Suite 207
Arcadia, CA 91007
Tel: 626.793.7338
Fax: 626.793.7378

Patient's Name: _____ Date _____ for

☐ Consultation Only ☐ Consultation and Treatment

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

R	A	B	C	D	E	F	G	H	I	J	L
	T	S	R	Q	P	O	N	M	L	K	

Appointment Time: _____ Time: _____ A.M. P.M.

Chief Complaint: _____

Anesthesia Preferred: ☐ General Anesthesia (going to sleep) ☐ Local Anesthesia

Special Instruction / Remarks: _____

_____

Current X-ray: ☐ Sent by mail ☐ Sent with Patient ☐ Please take one ☐ CBCT Scan

Referred by DR: _____

Reminder: If you are having <u>GENERAL ANESTHESIA (GOING TO SLEEP)</u>

- ✓ The night before your surgery, eat a light dinner early in the evening.
- ✓ NO FOOD or DRINK (including WATER) for 6 hours before the scheduled surgery.
- ✓ Wear short sleeved and loose fitting clothing (no high heels)
- ✓ Patient must be accompanied by a responsible adult who will drive patient home. The driver should plan to remain in the office during entire dental procedure.
- ✓ All minors MUST be accompanied by a parent or legal guardian.
- ✓ Have these supplies at home: Ibuprofen-type medication. Ice pack. 2-3 pillows. Cotton swabs.

PLEASE BRING THIS CARD WITH YOU, THANK YOU.