

ORAL AND MAXILLOFACIAL SURGERY

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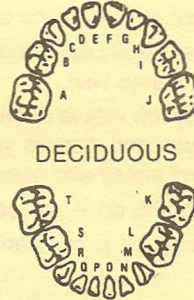
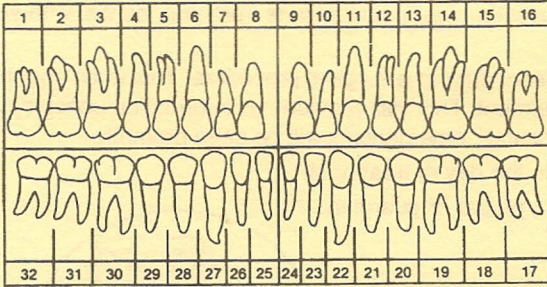
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CHARLES H. WALTER, D.D.S. • PHILLIP M. CHEN, D.D.S.

Name _____ Date _____

Patient Phone # _____

Remove teeth indicated by (x)



Remarks _____

Perform the following operation: _____

Consultation or diagnosis only regarding: _____

Additional Comments: _____

Referring Doctor: _____

IMPORTANT PATIENT INSTRUCTIONS ON BACK