SOCALDSC™

CARE DENTAL SPECIALTY CENTER

Oral & Maxillofacial Surgery

13079 Artesia Blvd.
Suite B-120
Cerritos, CA 90703
Tel: 562.402.2223
Fax: 562.924.7594
Frontoffice@caredsc.com

Date _____

PLEASE BRING THIS CARD TO YOUR APPOINTMENT

Patient Name _____

Appointment Date _____ AM PM

Month Day Time

Referring Dentist: _____ **Tel:** _____

- ☐ Consultation Only
- ☐ Consultation & Treatment

Service Requested:

- ☐ Extraction
- ☐ Bone Graft
- ☐ Frenectomy
- ☐ Expose & Bond
- ☐ Alveoplasty
- ☐ IV Sedation
- ☐ Lesion Evaluation
- ☐ Biopsy
- ☐ CBCT Scan
- ☐ Implant
- ☐ Call Prior to Consult/ Tx
- ☐ Other: _____

PLEASE CIRCLE AREA TO BE TREATED:

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	

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

COMMENTS:

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Special instructions for patients receiving
IV Sedation/ General Anesthesia will be given to patient upon treatment approval.