



# SOUTHEAST ORAL AND MAXILLOFACIAL SURGERY

11725 Highland Meadow • Houston, TX 77089  
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FRANK R.L. FRISHKEY, D.D.S.  
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### APPOINTMENT INFORMATION

This time is reserved specifically for you. If by necessity, you must cancel your appointment, please notify us at least one day in advance.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Day: \_\_\_\_\_

Introducing: \_\_\_\_\_

Referred By: \_\_\_\_\_

### WELCOME TO OUR ORAL & MAXILLOFACIAL SURGERY OFFICE

Our office is committed to providing you with the highest quality of care possible. To help us in scheduling your appointment, please remember the following:

- The initial visit, with the exception of certain emergency cases, is for consultation only. This enables us to fully evaluate your problems and tailor the care to your specific needs.
- Unmarried patients under eighteen (18) years of age must be accompanied by a parent or legal guardian at the time of the initial consult.
- Please bring all pertinent medical information and a list of all medications you are currently taking.
- Please alert the office if you have a medical condition that may be of concern prior to surgery (i.e. diabetes, high blood pressure, artificial heart valves and joints, rheumatic fever).
- Please bring both your medical and dental insurance information on the day of your appointment

**FOR DIRECTIONS TO OUR OFFICE PLEASE SEE REVERSE**

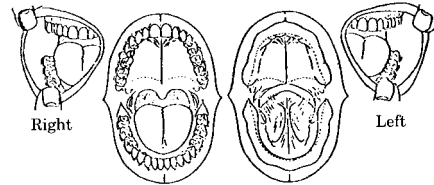
INSTRUCTIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

				A	B	C	D	E	F	G	H	I	J						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16				
Right									Left										
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17				
				T	S	R	Q	P	O	N	M	L	K						

Soft Tissue Chart



### PROCEDURES: (Please indicate below)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Extraction          | <input type="checkbox"/> Third Molar Consult | <input type="checkbox"/> Alveoloplasty |
| <input type="checkbox"/> Apicoectomy         | <input type="checkbox"/> Lesion Evaluation   | <input type="checkbox"/> Biopsy        |
| <input type="checkbox"/> Incision & Drainage | <input type="checkbox"/> Expose & Bond       | <input type="checkbox"/> Soft Tissue   |
| <input type="checkbox"/> Frenectomy          |  |  |

### CONSULTATION:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pre-Prosthetic     | <input type="checkbox"/> Orthognathic Eval.         | <input type="checkbox"/> Implants           |
| <input type="checkbox"/> Ridge Augmentation | <input type="checkbox"/> Carious or Abscessed Teeth | <input type="checkbox"/> Oral/Facial Lesion |
| <input type="checkbox"/> Bone Grafting      | <input type="checkbox"/> Other: _____               |   |

### RADIOGRAPHS:

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Being mailed     | <input type="checkbox"/> Given to Patient | <input type="checkbox"/> Please Take |
| <input type="checkbox"/> Will Bring X-ray | <input type="checkbox"/> No X-ray         |                                      |
| <input type="checkbox"/> Other: _____     |   |                                      |

### IMPLANTS:

Sites: \_\_\_\_\_

I prefer to use: \_\_\_\_\_



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