

Patient Name _____ Tel: _____

Referring Doctor _____

Dr. Garri MD DMD Dr. Lozano MD DDS Dr. Alcalde DDS PhD Dr. Borges DMD

PLEASE EVALUATE MY PATIENT FOR THE FOLLOWING

Extractions Teeth #: _____

Dental Implants
No. of Implants Desired _____

System of Preference Replace Straumann Zimmer Bio Horizons 3i Other _____
Location _____

Bone/Soft tissue Grafting _____

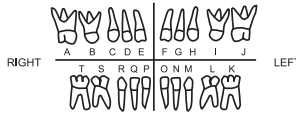
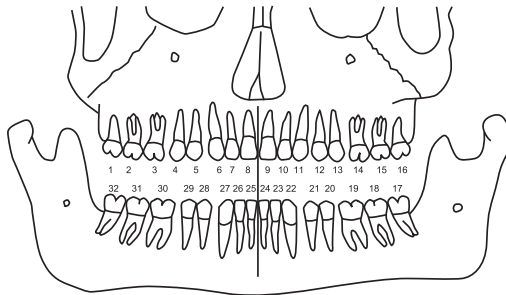
Malocclusion (Orthognathic Surgery) _____

Trauma _____

Biopsy/Pathology _____

Cosmetics _____

Other _____



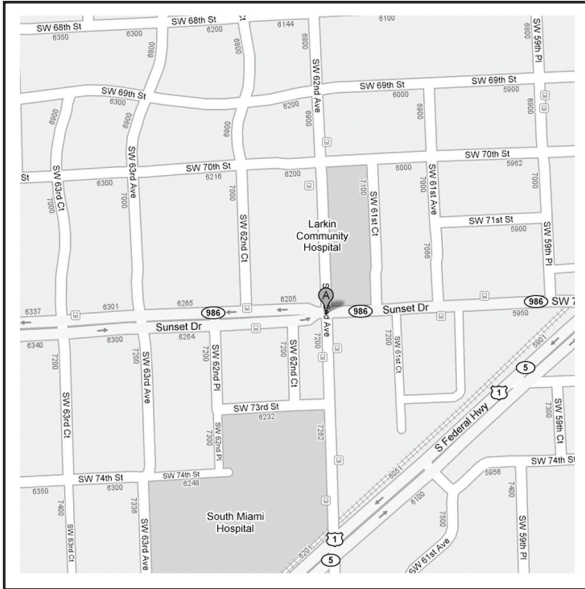
ANESTHESIA PREFERENCE

Local N₂O / O₂ IV General

Remarks _____

**SPECIAL INSTRUCTIONS
FOR PATIENTS
WHO WILL BE PUT TO SLEEP
(GENERAL ANESTHETIC)**

1. Do not eat or drink 8 hours prior to surgery.
2. Patient must bring a driver who should stay.
3. Loose-fitting clothes, no contacts, cosmetics, or nail polish.
4. Bring list of medications.



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